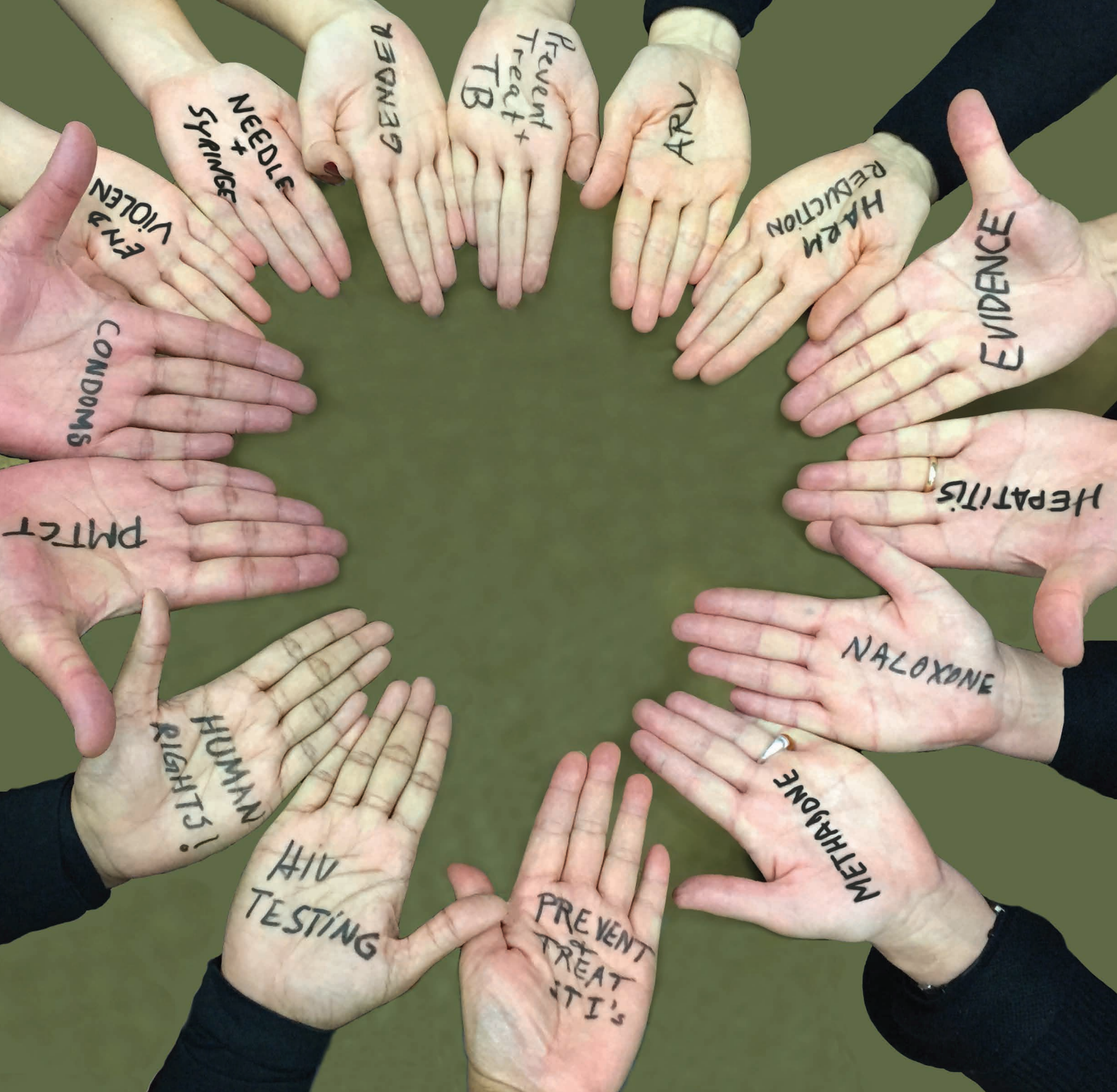




Implementing Comprehensive HIV and HCV Programmes with People Who Inject Drugs

PRACTICAL GUIDANCE FOR COLLABORATIVE INTERVENTIONS

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**This publication is dedicated with affection and respect to the memory of
Raffi Balian (1956–2017).**

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Edo Agustian, PKNI (Indonesia Network of People Who Use Drugs), Indonesia
Vladanka Andreeva, Joint United Nations Programme on HIV/AIDS, Bangkok
Tenu Avafia, United Nations Development Programme, New York
Sylvia Ayon, Kenya AIDS NGOs Consortium, Kenya
Annabel Baddeley, World Health Organization, Geneva
Nicholas Bartlett, Barnard College, USA
Anton Basenko, Alliance for Public Health, Ukraine
Ruth Birgin, International Network of Women Who Use Drugs, Australia
Holly Bradford, San Francisco Drug Users Union, Cambodia
Marina Braga, Alliance for Public Health, Ukraine
Olga Burgay, Alliance for Public Health, Ukraine
Jennifer Butler, United Nations Population Fund, Istanbul
Olga Byelyayeva, Eurasian Harm Reduction Network, Lithuania
Jude Byrne, AIVL (Australian Injecting and Illicit Drug Users League), Australia
Thomas Cai, AIDS Care China, China
Anand Chabungbam, Asian Network of People Who Use Drugs, Thailand
Nicolas Clark, World Health Organization, Geneva
Allan Clear, Harm Reduction Coalition, USA
Lynn Collins, United Nations Population Fund, New York
Joanne Csete, Independent consultant, USA
Olga Denisiuk, Alliance for Public Health, Ukraine
Tetiana Deshko, Alliance for Public Health, Ukraine
Vivek Divan, United Nations Development Programme, India
Richard Eliot, Canadian HIV/AIDS Legal Network, Canada
Florence Farrayan, Middle East and North African Network of People Who Use Drugs, Lebanon
Sergey Filippovych, Alliance for Public Health, Ukraine
Nathan Ford, World Health Organization, Geneva
Loon Gangte, International Treatment Preparedness Coalition, India
Brun Gonzalez, Espolea, Mexico
Kim Green, PATH, Viet Nam
Binod Gurung, Sathi Samuha, Nepal
Nikhil Gurung, Nirnaya, Nepal
Magdalena Harris, London School of Hygiene and Tropical Medicine, UK
Charles Henderson, New Zealand Needle Exchange Programme, New Zealand
Lee Hertel, Lee's Rig Hub, USA
Candice Humphrey, World Health Organization, Geneva
Victor Isakov, Alliance for Public Health, Ukraine

Zahedul Islam, Alliance for Public Health, Ukraine

Pye Jakobsson, Global Network of Sex Worker Projects, Sweden

Cheryl Johnson, World Health Organization, Geneva

Ralf Jürgens, Open Society Foundations, USA

Andrej Kastelic, Center for Treatment of Drug Addiction, University Psychiatric Hospital Ljubljana, Slovenia

Deanna Kerrigan, Johns Hopkins Bloomberg School of Public Health, USA

Giten Khwairakpam, TREAT Asia (Therapeutics Research, Education, and AIDS Training in Asia), Thailand

Sergey Kolomiets, Alliance for Public Health, Ukraine

Boyan Konstantinov, United Nations Development Programme, New York

Anita Krug, Youth RISE, Australia

Igor Kuzmenko, DUNews, Ukraine

Olivier Lermet, United Nations Office on Drugs and Crime, Bangkok

Jay Levy, International Network of People Who Use Drugs, UK

Konstantin Lezhentsev, ECUO (East Europe and Central Asia Union of PWLH), Ukraine

Rick Lines, Harm Reduction International, UK

Niklas Luhman, Médecins du Monde, France

Virginia Macdonald, World Health Organization, Geneva

Ludmila Maistat, Alliance for Public Health, Ukraine

Susan Masanja, Tanzanian Network of People Who Use Drugs, Tanzania

Erika Matuizaite, Eurasian Harm Reduction Network, Lithuania

Olena Mazhnaya, Alliance for Public Health, Ukraine

Susie McLean, International HIV/AIDS Alliance, UK

Judy Mungai, Kenya Network of People Who Use Drugs, Kenya

Palani Narayanan, Independent consultant, Malaysia

Bill Nelles, International Network of People Who Use Drugs, Canada

Noy Ngamsee, Independent consultant, Thailand

Alireza Noroozi, Substance Abuse Prevention & Treatment Office, Ministry of Health and Medical Education, Iran

Dasha Ocheret, Eurasian Harm Reduction Network, Lithuania

Fabrice Olivet, ASUD (Auto Support des Usagers de Drogues), France

Shiba Phurailatpam, APN+ (Asia Pacific Network of People Living with HIV/AIDS), Thailand

Sandrine Pont, Médecins du Monde, France

Joëlle Rabot-Honoré, CUT (Collectif Urgence Toxida), Mauritius

James Robertson, International HIV/AIDS Alliance, India

Michelle Rodolph, World Health Organization, Geneva

Anyar Sarang, Andrey Rylkov Foundation, Russian Federation

Rebecca Schleifer, United Nations Development Programme, New York

Shona Shonning, Independent consultant, USA

Olena Shost, Alliance for Public Health, Ukraine

Liudmyla Shulga, Alliance for Public Health, Ukraine

Marina Smelyanskaya, United Nations Development Programme, New York

Pavlo Smyrnov, Alliance for Public Health, Ukraine

Georgi Soselia, Georgian Network of People Who Use Drugs, Georgia

Mat Southwell, CoAct, UK

Steffanie Strathdee, University of California, San Diego, USA

Robert Suarez, VOCAL-NY (Voices of Community Activists and Leaders), USA
Emilis Subata, Eurasian Harm Reduction Network, Lithuania
Paisan Suwannawong, Thai AIDS Treatment Action Group, Thailand
Tracy Swan, TAG (Treatment Action Group), USA
Omar Syarif, APN+ (Asia Pacific Network of People Living with HIV/AIDS), Indonesia
Pascal Tanguay, Population Services International, Thailand
Brigitte Tenni, Nossal Institute for Global Health, Australia
Anastasia Teper, VOCAL-NY (Voices of Community Activists and Leaders), USA
Marian Ursan, Carusel, Romania
Nick Walsh, World Health Organization, Manila
Bangyuan Wang, International HIV/AIDS Alliance, UK
Micky Webb, International Network of People Who Use Drugs, UK
Janine Wildschut, AIDS Foundation East–West, Netherlands
Yogie Wirastra, Asian Network of People Who Use Drugs, Thailand
Ilya Zhukov, United Nations Population Fund, New York

COORDINATING GROUP

Elie Aaraj, Middle East and North Africa Harm Reduction Association, Lebanon
Eliot Albers, International Network of People Who Use Drugs, UK
James Baer, Coordinating editor, UK
Raffi Balian, South Riverdale Community Health Centre, Toronto, Canada
Judy Chang, International Network of People Who Use Drugs, Italy
Monica Ciupagea, United Nations Office on Drugs and Crime, Vienna
Clif Cortez, United Nations Development Programme, New York
Alison Crocket, Joint United Nations Programme on HIV/AIDS, Geneva
Zoë Dodd, Toronto Drug Users' Union, Canada
Mauro Guarinieri, The Global Fund to Fight AIDS, Tuberculosis and Malaria, Geneva
Fabienne Hariga, United Nations Office on Drugs and Crime, Vienna
Annie Madden, AIVL (Australian Injecting and Illicit Drug Users League), Australia
Billy Pick, United States Agency for International Development, USA
Tim Sladden, United Nations Population Fund, New York
Marina Smelyanskaya, United Nations Development Programme, New York
Annette Verster, World Health Organization, Geneva

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Acronyms

APT	acute psychostimulant toxicity
ART	antiretroviral therapy
ATS	amphetamine-type substances
CBO	community-based organization
CBT	cognitive behavioural therapy
HBV	hepatitis B virus
HCV	hepatitis C virus
HIV	human immunodeficiency virus
HTS	HIV testing services
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
IEC	information, education and communication
INPUD	International Network of People Who Use Drugs
IPT	isoniazid preventive therapy
LDSS	low-dead-space syringe
M&E	monitoring and evaluation
MDR-TB	multidrug-resistant tuberculosis
MMT	methadone maintenance treatment
NGO	nongovernmental organization
NPS	novel psychoactive substances
NSP	needle and syringe programme
OST	opioid substitution therapy
PEP	post-exposure prophylaxis
PrEP	pre-exposure prophylaxis
PWID	people who inject drugs
SDG	Sustainable Development Goal
SRH	sexual and reproductive health
TB	tuberculosis
UIC	unique identifier code
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
WHO	World Health Organization

Glossary

Community: In most contexts in this tool, “community” refers to populations of people who inject drugs, rather than the broader geographic, social or cultural groupings of which they may be a part. However, our definition of community takes into account the fact that people may move into or out of injecting drug use at various times in their lives, whether by their own choice or because of circumstances beyond their control, but may maintain community connectedness (see definition below). Thus, “community members” are people who inject drugs or people with community connectedness; “outreach to the community” means outreach to people who inject drugs; and “community-led interventions” are interventions led by people who inject drugs or people with community connectedness.

Community connectedness: People who have previously injected drugs who continue to maintain associations, shared values and understandings with others who inject drugs may be considered community members by virtue of their “community connectedness”. Community connectedness also derives from the fact that people not currently using drugs, including people on opioid substitution therapy, are frequently subject to the same stigma and discrimination as people currently using drugs.

Drop-in centre is a place where people who inject drugs may gather to relax, meet other community members, and hold social events, meetings or training. See Chapter 4, Section 4.6, for details.

Drug use refers to the use of psychoactive drugs for nonmedical reasons, including drugs that are illegal, controlled, prescription or non-prescription (“over-the-counter”).

Implementing organization is an organization delivering an intervention to people who inject drugs, with a client-centred approach. It may be a governmental, non-governmental, community-based or community-led organization, and may work at a state, provincial, district or local level. Sometimes a non-governmental organization provides services through subunits at multiple locations within an urban area, and in this case, each of those subunits may also be considered an implementing organization.

Peer outreach worker is used to mean a person who injects drugs, or a person with community connectedness, who conducts outreach to other people who inject drugs, and who is not generally full-time staff of an HIV prevention intervention (full-time staff might be called “staff outreach workers” or simply “outreach workers”). Peer outreach workers may also be known by other terms, including “peer educators”, “community outreach workers” or “outreach workers”. However, the terms “peer” or “community” should not be understood or used to imply that they are less qualified or less capable than staff outreach workers.

Young people who use or inject drugs are those in the age range 10–24 years, in accordance with the Interagency Working Group on Key Populations’ *HIV and young people who inject drugs: a technical brief* (Geneva: World Health Organization; 2015).



Introduction

Introduction

In all regions of the world, people who inject drugs are disproportionately affected by HIV.¹ Globally, people who inject drugs are 28 times more likely to be living with HIV than the general population. The United Nations Office on Drugs and Crime (UNODC), the World Health Organization (WHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Bank estimate that worldwide as of 2014, about 11.7 million² people inject drugs, of whom an estimated 14% (1.6 million) are living with HIV.³ Injecting drug use accounts for 30% of new HIV infections outside sub-Saharan Africa. People who inject drugs also have higher rates of hepatitis C (HCV) and tuberculosis than the general population. The global rate of HCV among people who inject drugs is 52%, greatly surpassing even the high prevalence of HIV among them.

Among the immediate causes of these disparities is the lack of consistent access to sterile injecting equipment, opioid substitution therapy (OST), condoms and lubricant, HIV testing and antiretroviral therapy (ART) for those who are living with HIV. In 2014, out of 158 countries reporting injecting drug use, only 90 provided needle and syringe programmes in the community and eight in prisons, and only 80 provided OST (including 43 in prisons).⁴ UNAIDS estimated that USD\$2.3 billion was needed in 2015 to fund comprehensive harm reduction programmes for people who inject drugs, but a recent study showed that international donors were investing only 7% of this sum.⁵

The Sustainable Development Goals (SDGs), adopted in 2015, include Goal 3, “Ensure healthy lives and promote well-being for all at all ages.”⁶ This goal includes a commitment to end the AIDS epidemic and to combat hepatitis (among other diseases). The UNAIDS Fast-Track strategy is aligned with the SDGs and emphasizes a five-year window (2016–2021) for rapid acceleration of HIV treatment and prevention services, with the aim of ending the AIDS epidemic by 2030.⁷ To achieve this, the strategy articulates the “90–90–90” treatment target⁸ and a prevention target of reducing the annual number of new HIV infections to 500,000. The Fast-Track strategy was adopted by the United Nations Political Declaration on AIDS 2016, in which member states committed to encouraging those member states with high HIV incidence to “tak[e] all appropriate steps to ensure that 90% of those at risk of HIV infection are reached by comprehensive prevention services.”⁹

1 The terms “people who inject drugs” and “people who use drugs” are used throughout this publication, consistent with the International Network of People Who Use Drugs’ [Statement and position paper on language, identity, inclusivity and discrimination](#) (2011). These terms identify people who use drugs as people first and foremost, for whom drug use or injection drug use is just one facet of their lives.

2 Range: 8.4–19.0 million.

3 All statistics in this paragraph are from the [World drug report 2016](#). Vienna: United Nations Office on Drugs and Crime; 2016.

4 [The global state of harm reduction 2014](#). London: Harm Reduction International; 2014.

5 [The funding crisis for harm reduction: donor retreat, government neglect and the way forward](#). London: International Harm Reduction Association; 2014.

6 [Transforming our world: the 2030 Agenda for Sustainable Development](#). A/RES/70/1. New York (NY): United Nations; 2015.

7 [UNAIDS Strategy 2016–2021: on the Fast-Track to end AIDS](#). Geneva: Joint United Nations Programme on HIV/AIDS; 2015.

8 90% of people living with HIV will get tested and know the result, 90% of people who know they are living with HIV will be on treatment, and 90% of those on treatment will have undetectable levels of HIV.

9 [Political declaration on HIV and AIDS: on the fast-track to accelerate the fight against HIV and to end the AIDS epidemic by 2030](#). A/70/L.52. New York (NY): United Nations; 2016.

Harm reduction refers to policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of licit and illicit drugs. The harm reduction approach is based on a strong commitment to public health and human rights. Harm reduction helps protect people from preventable diseases and death from overdose, and helps connect marginalized people with social and health services. All major United Nations bodies have endorsed a comprehensive package of harm reduction interventions (Table 1), which forms an evidence-based approach to HIV prevention, treatment and care for people who inject drugs. The comprehensive package is also reflected in the Outcome Document of the 2016 United Nations General Assembly Special Session (UNGASS) on the World Drug Problem, which calls for “effective measures aimed at minimizing the adverse public health and social consequences of drug abuse, including appropriate medication-assisted therapy programmes, injecting equipment programmes, as well as antiretroviral therapy and other relevant interventions that prevent the transmission of HIV, viral hepatitis and other bloodborne diseases associated with drug use”.¹⁰

Table 1 Comprehensive package of harm reduction interventions

1. Needle and syringe programmes
2. Opioid substitution therapy
3. HIV testing services
4. Antiretroviral therapy
5. Prevention and treatment of sexually transmitted infections
6. Condom programmes for people who inject drugs and their sexual partners
7. Targeted information, education and communication
8. Prevention, vaccination, diagnosis and treatment of viral hepatitis B and C
9. Prevention, diagnosis and treatment of tuberculosis
10. Community distribution of naloxone

Source: WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users–2012 revision. Geneva: World Health Organization; 2013. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations–2016 update. Geneva: World Health Organization; 2016.

It is recognized that “criminalization of drug use, restrictive drug policies and aggressive law-enforcement practices are key drivers of HIV and hepatitis C epidemics among people who inject drugs,”¹¹ a view that is shared by several United Nations agencies.^{12,13} These factors, together with discrimi-

10 Our joint commitment to effectively addressing and countering the world drug problem. Outcome document of the United Nations General Assembly Special Session on the World Drug Problem. A/RES/S-30/1. New York (NY): United Nations; 2016.

11 Science addressing drugs and HIV: state of the art of harm reduction. A scientific statement. Vienna: United Nations Office on Drugs and Crime; 2014. Science addressing drugs and HIV: state of the art. 2nd scientific statement. Vienna: United Nations Office on Drugs and Crime; 2016.

12 Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations–2016 update. Geneva: World Health Organization; 2016.

13 Do no harm: health, human rights and people who use drugs. Geneva: Joint United Nations Programme on HIV/AIDS; 2016.

nation, marginalization, stigmatization and violence, drive people who inject drugs underground and exclude them from proper access to the harm reduction and health services they need to prevent overdose and protect themselves from HIV and hepatitis C.

Therefore, in addition to the availability of essential services for HIV, interventions are needed to enable access to these services for people who inject drugs. WHO's *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations–2016 update* lists several “critical enablers”—strategies and approaches that can improve the accessibility, acceptability, availability and uptake of interventions for key populations most at risk of HIV, including people who inject drugs (Table 2).

Table 2 Critical enablers for key populations

Laws, policies and practices should be reviewed and, where necessary, revised by policy-makers and government leaders, with meaningful engagement of stakeholders from key population groups, to allow and support the implementation and scale-up of health-care services for key populations. For people who inject drugs:

- Countries should work towards developing policies and laws that decriminalize the use of sterile needles and syringes (and that permit needle and syringe programmes) and that legalize OST for people who are opioid-dependent.
- Countries should work towards developing policies and laws that decriminalize injection and other use of drugs and, thereby, reduce incarceration.
- Countries should ban compulsory treatment for people who use or inject drugs.

Countries should work towards implementing and enforcing antidiscrimination and protective laws, derived from human-rights standards, to eliminate stigma, discrimination and violence against people from key populations.

Health services should be made available, accessible and acceptable to key populations, based on the principles of medical ethics, avoidance of stigma, nondiscrimination and the right to health. Health-care workers should receive appropriate recurrent training and sensitization to ensure that they have the skills and understanding to provide services for adults and adolescents from key populations based on all persons' rights to health, confidentiality and non-discrimination.

Programmes should work towards implementing a package of interventions to enhance community empowerment among key populations.

Violence against people from key populations should be prevented and addressed in partnership with key population-led organizations. All violence against people from key populations should be monitored and reported, and redress mechanisms should be established to provide justice.

Source: *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations–2016 update*. Geneva: World Health Organization; 2016.

People who inject drugs share with everyone else a human right to the highest attainable standard of health, with health care provided without discrimination and regardless of the legal status of drug use. Health-care workers, programme managers and national leaders should ensure that people who inject drugs have full access to harm reduction services, services for HIV and hepatitis C prevention, testing, treatment and care, guided by the principles of health for all and human rights.¹⁴ The 2016 UNGASS Outcome Document calls on governments to “consider ensuring access to such interventions, including in treatment and outreach services, prisons and other custodial settings”.

The focus of this tool

The primary focus of this tool is people who inject drugs because of the particular vulnerability to HIV and HCV associated with injecting practices. However, some people who do not inject but use stimulants and other psychoactive drugs can be at high risk of contracting HIV through unprotected sex, and they are subject to structural barriers similar to those faced by people who inject drugs. Therefore, much of the information in this tool—particularly the chapters related to structural barriers and some of the health-care interventions (Chapters 1–3)—is relevant to people who use drugs in general.

As noted, people who inject drugs are vulnerable not only to HIV and HCV, but also to other bloodborne viruses such as hepatitis B, as well as to sexually transmitted infections and tuberculosis. For the sake of conciseness, this tool refers primarily to HIV and HCV prevention, but Chapter 3 in particular addresses the diagnosis, treatment and care of other infections to which people who inject drugs are disproportionately vulnerable.

The purpose of this tool

Previously published United Nations (UN) guidance documents describe the content of effective HIV and HCV prevention interventions for people who inject drugs, in the context of harm reduction¹⁵ and HIV prevention for key populations (Table 1).⁹ UN guidance is also grounded in an approach expressed in the critical enablers described in Table 2—strategies, activities and approaches to increase the accessibility, acceptability, coverage, quality and uptake of interventions and services for key populations.⁹ This tool offers practical advice on how to implement these programmes and these approaches for and with people who inject drugs, across the full continuum of HIV and HCV prevention, diagnosis, treatment and care, aligned with UN guidance. It contains examples of good practice from around the world that may support efforts in planning programmes and services, and describes issues that should be considered and how to overcome challenges.

This tool does not seek to ignore the complex policy and legislative environment around drugs and injecting drug use in most countries, nor the need for advocacy to confront the stigma, discrimination and human-rights violations faced by people who inject drugs. However, it aims primarily

¹⁴ Consensus statement on drug use under prohibition: human rights, health and the law. International Network of People Who Use Drugs; 2015.

¹⁵ WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users—2012 revision. Geneva: World Health Organization; 2013. (Also referred to widely as the Target Setting Guide.)

to address the question: what can we do now, with the resources we have, in the kinds of environments we face, to prevent the spread of HIV and hepatitis C among people who inject drugs?

The tool describes how services can be designed and implemented to be accessible and acceptable to people who inject drugs. This requires respectful and ongoing engagement, and this publication gives particular attention to programmes run in close partnership with, or by, organizations of people who use drugs. It is itself the product of a collaborative process including people who inject drugs, advocates, service-providers, researchers, government officials and nongovernmental organizations (NGOs) from around the world, as well as United Nations agencies and other development partners.

The intended users of this tool are public-health officials and managers of HIV and harm reduction programmes; nongovernmental, community and civil-society organizations, including networks of people who use drugs; and health workers. It will also be of interest to advocates and activists for the rights of people who use drugs, and to international funding agencies and health policy-makers.

This tool is one of a series of publications that address HIV prevention with key populations. The others in this series are *Implementing comprehensive HIV and STI programmes with sex workers: practical guidance from collaborative interventions* (WHO; 2013), informally known as the sex worker implementation tool or SWIT; *Implementing comprehensive HIV and STI programmes with men who have sex with men: practical guidance for collaborative interventions* (UNFPA; 2015) or MSMIT; and *Implementing comprehensive HIV and STI programmes with transgender people: practical guidance for collaborative interventions* (UNDP; 2016) or TRANSIT. In keeping with this style, users of this tool may wish to refer to it informally as the IDUIT.

How to use this tool

The tool's five chapters fall broadly into three parts (Figure 1). The first two chapters describe approaches and principles for developing programmes and critical enablers (interventions that address structural factors underlying the HIV and HCV epidemics among people who inject drugs). Chapters 3 and 4 describe how to implement recommended interventions for HIV prevention, diagnosis, care and treatment. Finally, Chapter 5 describes how to manage programmes.

Each chapter begins with an introduction that defines the topic and explains why it is important. Interventions are then broken down into stages or steps wherever possible, to make them easy to follow. Topics or points of particular interest are presented in text boxes. Case examples from programmes around the world are presented in shaded boxes. These examples do not describe an entire programme in detail but highlight specific aspects related to programming with people who inject drugs that have worked well in their contexts. They illustrate how an issue or challenge has been addressed and aim to inspire ideas about approaches that could work in the reader's own context. The forms, charts etc. presented from various programmes have the same purpose. Each chapter ends with a list of further resources—tools, guidelines and other practical publications—available online.

Figure 1 Structure of the tool



Chapter ① Community Empowerment describes how empowerment of people who inject drugs is both an intervention in itself and also essential for ensuring community-led planning, implementation and monitoring of all aspects of prevention, treatment and care for HIV and other blood-borne diseases. It also shows how groups and networks can be formed, and practical ways to strengthen their capacity for harm reduction and advocacy.

Chapter ② Legal Reform, Human Rights, Stigma and Discrimination focuses on the urgent need to counteract the impact of stigma, discrimination and criminalization upon people who inject drugs, for protection of their human rights and for effective HIV and HCV prevention.

Chapter ③ Health and Support Services describes considerations for delivering the comprehensive package of harm reduction services for people who inject drugs.

Chapter ④ Service Delivery Approaches describes how to design services and how community members can be involved in varying aspects of service delivery, including (but not limited to) outreach to people who inject drugs, peer navigation and running drop-in centres.

Chapter ⑤ Programme Management provides practical guidance on planning, starting, scaling up, managing and monitoring an effective programme.

Although each chapter is subdivided to make it easier to find and use information, the reader is urged not to view them as separate or independent of one another. No single, stand-alone service modality or intervention will suffice when designing and implementing programmes tailored to the needs of people who inject drugs. Cross-referencing is provided to assist the reader in making connections between chapters.

Guiding principles for implementing comprehensive HIV and HCV programmes with people who inject drugs

Several principles underlie the implementation of HIV services for people who inject drugs and are articulated in this tool.

Human rights: Fundamental to the development of this tool is the respect, protection and fulfilment of human rights for people who inject drugs. Human rights underpins approaches to community empowerment (Chapter 1), prevention of stigma, discrimination and violence (Chapter 2), and access to services for the prevention, diagnosis, treatment and care of HIV and HCV (Chapters 3 and 4).

Community empowerment is the process whereby people who inject drugs are supported to address for themselves the structural constraints to health, human rights and well-being that they face, and improve their access to services, including to reduce the risk of acquiring HIV and HCV, and to provide treatment and care for those living with HIV, HCV and other health problems. Community empowerment is an essential approach that underlies all the interventions and programme components described in this tool, and is inseparable from them.

Community participation and leadership are essential in the design, implementation, monitoring and evaluation of programmes. Participation and leadership help to build

trust among those whom programmes are intended to serve, make programmes more comprehensive and more responsive to the needs of people who inject drugs, and create more enabling environments for HIV prevention.

Acceptability of services: Interventions must be respectful, acceptable, appropriate and affordable to people who inject drugs in order to encourage their participation and ensure their retention in care. Services that are acceptable are more likely to be used in a regular and timely way. Consultation on service planning and design with people who inject drugs, and mechanisms for them to provide regular feedback, improve the acceptability of services.

Access to justice is a major priority for people who inject drugs, due to the illegality of injecting drug use in most countries. Access to justice includes freedom from arbitrary arrest and detention, the right to a fair trial, freedom from torture and cruel, inhuman and degrading treatment, and the right to the highest attainable standard of health, including in prisons and other closed settings.

Access to quality health care: Evidence-based, high-quality health services should be accessible to people who inject drugs, and health-care providers and institutions must serve people based on the principles of medical ethics and the human right to health care.

Health literacy: Health services should regularly and routinely provide accurate health and treatment information to people who inject drugs to help them make decisions about their health and about HIV risk behaviours. Health services should also strengthen providers' ability to prevent and treat HIV and HCV in people who inject drugs.

Integrated service provision: Wherever possible, service delivery for people who inject drugs should be integrated. Integrated services provide opportunities for client-centred prevention, care and treatment of the multitude of illnesses, and to address various structural issues, that affect people who inject drugs. Integrated services also facilitate better communication among services. Where integrated services are not possible, strong links among health and other social services working with people who inject drugs should be established and maintained.

The principles that underlie this tool and the organizational approaches that it presents are universally relevant to all settings, and are as applicable to high-income countries as they are to low- and middle-income settings.



1

Community Empowerment



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What's in this chapter?

Community empowerment is a key principle for all of the interventions and approaches described in this tool. This chapter:

- **defines community empowerment** and explains why it is fundamental to addressing HIV and hepatitis C among people who inject drugs in an effective and sustainable way (Section 1.1)
- describes **seven elements of community empowerment**, with examples from a number of programmes (Section 1.2)
- gives examples of **indicators** to measure the empowerment of organizations of people who inject drugs (Section 1.3).

The chapter also presents a list of **further resources** (Section 1.4).

1.1 Introduction

Since well before the HIV epidemic, people who inject or otherwise use drugs have been proactive in protecting their health, fighting for their rights and supporting active, caring and committed communities. Organizations led by people who use drugs have played a central and creative role in the HIV response in many parts of the world, even in the most repressive environments. Community empowerment has been key to this success.

Community empowerment refers to a process of enabling groups or communities of people to increase control over their lives. It means more than the involvement, participation or engagement of communities in pre-existing or new programmes: it implies community ownership, and action that explicitly aims at social and political change. Community empowerment addresses the social, cultural, political and economic determinants that affect health and seeks to build partnerships with other sectors in finding solutions.

There have been many successful partnerships between communities of people who inject drugs and other actors—such as researchers, advocates, and service-providers who are not from communities of people who inject drugs—that have led to the attainment of common goals. The most noteworthy and efficacious programmes are those that acknowledge and support community empowerment as a key principle and practice.

In the field of HIV, hepatitis C (HCV) and drug use, community empowerment describes a process whereby people who inject drugs take individual and collective ownership of activities, programmes and policies to achieve the most effective responses to HIV and HCV, and to address social and structural barriers to their health and their human rights. This may mean that people who inject drugs:

- come together for mutual assistance
- form a collective identity with common goals and address their collective needs in a supportive environment
- identify their own priorities and the appropriate strategies to address these
- advocate collectively for their rights as people who inject drugs and as human beings
- provide and facilitate access to HIV and HCV prevention, care and treatment, and support services
- participate meaningfully in all aspects of programme design, implementation, delivery, management, monitoring and evaluation (M&E)
- build and strengthen partnerships with government, civil society, local allies and development partners.

Box 1.1

Defining community

In most contexts in this tool, “community” refers to populations of people who inject drugs, rather than the broader geographic, social or cultural groupings of which they may be a part. However, our definition of community takes into account the fact that people may move into or out of injecting drug use at various times in their life, whether by their own choice or because of circumstances beyond their control.

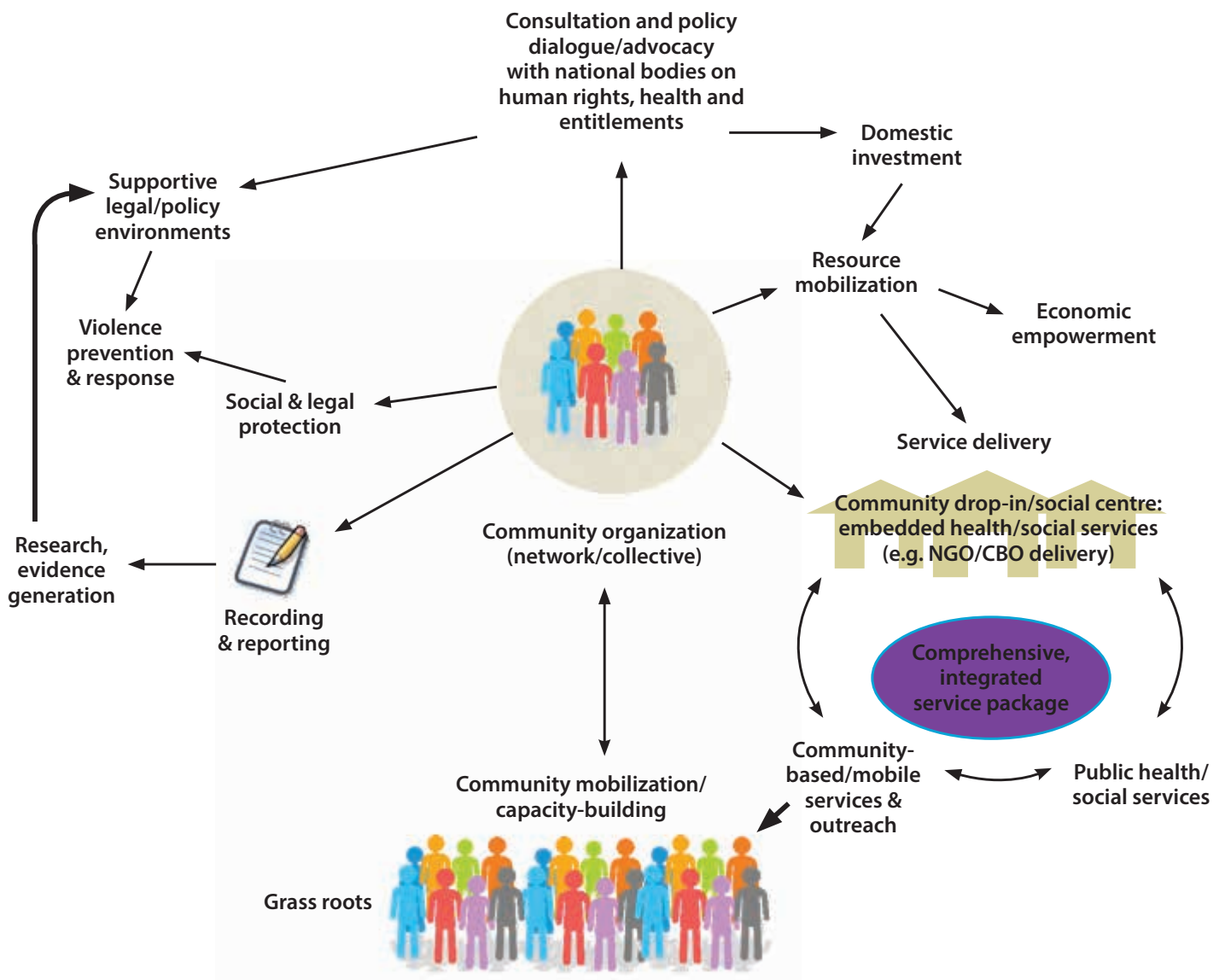
People who have injected drugs who continue to maintain associations, shared values and understandings with others who inject drugs may be considered community members by virtue of their “community connectedness”. Community connectedness also derives from the fact that people not currently using drugs, including people on opioid substitution therapy (OST), are frequently subject to the same stigma and discrimination as people currently using drugs.

In this tool, “outreach to the community” therefore means outreach to people who inject drugs, “community-led interventions” are interventions led by people who inject drugs or people with community connectedness, and “community members” are people who inject drugs or people with community connectedness.

Investing time and resources in community empowerment not only is the right thing to do but also makes good sense. Strategies for HIV and HCV prevention are more relevant, effective and sustainable when conducted within a community empowerment framework. People who inject drugs are experts in their own lives, and community-led organizations around the world have fostered improved access to quality and uptake of services, use of sterile needles and syringes, and engagement by people who inject drugs in national policies and programmes. Scaling up comprehensive, community empowerment-based HIV interventions helps prevent significant numbers of new HIV infections, particularly in settings with high rates of HIV and highly concentrated populations of people who inject drugs. Meaningful partnerships with community-led organizations should be developed, nurtured and maintained throughout the life cycle of HIV and HCV responses.

Community empowerment for people who inject drugs can be seriously hampered by repressive drug control policies, laws, practices and regulations against people who inject drugs, as well as stigma and discrimination. Because of these structural barriers, in some contexts people who inject drugs may not be in a position to initiate programmes to prevent HIV and HCV. Most programmes are therefore started by other service-providers (e.g. governmental or nongovernmental organizations) with varying degrees of experience in working with communities of people who inject drugs. This chapter addresses such organizations in particular and shows how they can work in partnership with people who inject drugs in order to empower communities and create effective programming. Organizations that work in meaningful partnership with people who inject drugs understand community empowerment as more than a set of activities; it is an approach that can be integrated into all aspects of health and HIV programming. It is the cornerstone of an effective and human rights-based approach to HIV and, as such, underpins all the recommendations and components presented in this tool.

Figure 1.1 A community-focused, rights-based framework for HIV and HCV prevention



This chapter explains the principles and practices of community empowerment, so that they can be better integrated into HIV programme design and implementation for people who inject drugs. The chapter also gives guidance on how to strengthen organizational and programme management of community-led organizations.

Box 1.2

Community empowerment and the Vancouver Declaration (2006)

Global international activists who use drugs issued the Vancouver Declaration in 2006 to articulate principles for members of the drug-using community to collaborate in claiming their human rights and reforming oppressive laws. A number of these principles, excerpted below, are principles of community empowerment:

It is time to raise our voices as citizens, establish our rights and reclaim the right to be our own spokespersons striving for self-representation and self-empowerment:

- to enable and empower people who use drugs legal or deemed illegal worldwide to survive, thrive and exert our voices as human beings to have meaningful input into all decisions that affect our own lives
- to use our own skills and knowledge to train and educate others, particularly our peers and any other fellow-citizens concerned with drugs in our communities.

We strive to:

- value and respect diversity and recognize each other's different backgrounds, knowledge, skills and capabilities, and cultivate a safe and supportive environment within the network regardless of which drugs we use or how we use them
- spread information about our work in order to support and encourage development of user organizations in communities/countries where there are no such organizations
- promote tolerance, cooperation and collaboration, fostering a culture of inclusion and active participation
- [enact] democratic principles and create a structure that promotes maximum participation in decision-making
- [promote] maximum inclusion with special focus to those who are disproportionately vulnerable to oppression on the basis of their gender identity, sexual orientation, socioeconomic status, religion etc.

1.2 Key elements of community empowerment

Community empowerment should take a flexible approach, adapted to the needs of each community. There is no fixed order in which the elements depicted in Figure 1.2 should be addressed; the process may flow from working with communities of people who inject drugs to community-led outreach, the development and strengthening of organizations and networks led by people who inject drugs and, consistent with local needs and contexts, shaping human rights-based policies and creating an enabling environment for a sustainable movement.

Figure 1.2 Key elements of community empowerment among people who inject drugs

This process represents a paradigm shift, from people who inject drugs being recipients of services to the self-determination of communities of people who inject drugs. Even when initiated by organizations that are not community-led, community empowerment builds a social movement where community members collectively exercise their rights, are recognized as an authority and as an equal partner in the planning, implementation, provision and monitoring of health and social services. Organizations that aim to work effectively and meaningfully with people who inject drugs should support and advocate for community empowerment where possible.

Community systems strengthening is an approach that promotes the development of informed, capable and coordinated community-led organizations, groups or other structures, to enable them to contribute as partners alongside other actors to the long-term sustainability of community-based health and other interventions. Community systems strengthening also includes creation of an enabling environment within which this community development can occur (see Box 1.3).

Box 1.3

Core components of community systems strengthening

- **Enabling environments and advocacy**—includes community engagement and advocacy to improve policy, laws, governance and the social determinants of health.
- **Community networks, linkages and partnerships**—to enable effective activities, service delivery and advocacy, and to maximize resources and impact.
- **Resource- and capacity-building**—human resources (with appropriate personal, technical and organizational capacities), financing (operational and core funding) and material resources (infrastructure, information and essential commodities).
- **Community activities and service delivery**—accessible to all who need them, evidence-informed and based on community members' assessments of their resources and needs.
- **Organizational and leadership strengthening**—including management, accountability and leadership.
- **Monitoring and evaluation and planning**—including M&E systems, situation assessment, evidence-building and research, learning, planning and knowledge management.

Source: [Community Systems Strengthening framework: revised edition February 2014](#). Geneva: Global Fund to Fight AIDS, Tuberculosis and Malaria; 2014.

At the local level, this means that organizations and networks of people who inject drugs are members of planning, funding and implementation committees and other relevant bodies. It also means strengthening the capacity of community-led organizations to deliver services, manage programmes, develop leadership and handle human and financial resources on a sustained basis, especially in the face of changes in donor funding or the leadership of government or NGOs. Connections with national, subregional, regional and global networks of people who inject drugs are useful to exchange knowledge, experience and support.

1.2.1 Working with communities of people who inject drugs

Community empowerment takes significant time and effort. Trust, empathy and respect are important for all partners. Building trust involves treating people who inject drugs with dignity and respect, listening to and addressing their concerns, and working with them throughout the process of developing and implementing an intervention. The goal is to ensure that organizations of people who inject drugs are respected as partners by officials and service-providers in health, law enforcement and social services. Where informal groups or more formal organizations of people who inject drugs already exist in a chosen service area, programme managers should work with them, as these are likely to be community-led rather than simply community-based (see Box 1.6).

In the initial stages of community empowerment, people who inject drugs may have limited experience in organizing as a group, and service-providers may not be accustomed to working with community members as equals. National, regional and global networks of people who inject drugs are able to provide essential technical assistance and support (see Section 1.2.4). Allies, whether individuals or organizations, also have an important role in facilitating meaningful participation of people who inject drugs (see Section 1.2.5). Meaningful participation means that people who inject drugs:

- choose whether to participate
- choose how they are represented, and by whom
- choose how they are engaged in the process
- have an equal voice in how partnerships are managed.

Box 1.4

Case example: Community involvement in policy advocacy in Nepal

Recognizing the lack of specific laws or policies in Nepal to support people who inject drugs and the lack of services at the community level, Naya Goreto, a local nongovernmental organization (NGO), created *Bridging the Gap: Health and Human Rights Programme for the Key Population*. The programme aims to engage partners ranging from parliamentarians to local councillors, public-health officials to health volunteers in advocacy on issues of concern to the community of people who inject drugs.

Naya Goreto emphasizes the meaningful participation of people who inject drugs at all levels of the programme. More than 200 people from the community have been trained to lead activities ranging from situation analysis to advocacy campaigning and programme monitoring. The programme has brought together key stakeholders to establish a committee that lobbies for the health and human rights of people who inject drugs. Empowerment activities have included advocacy in small-group environments; forming advocacy networks for broader reach; linking people who inject drugs with experts and other concerned stakeholders for information on programmes and budgets; mobilization of community representatives to participate in consultation meetings with key government officials; lobbying duty-bearers for the health and human rights of the injecting community.

Naya Goreto has built strong partnerships between people who inject drugs, creating a sense of solidarity to collectively address the issues that directly affect them. Such issues are now included in the yearly action plans of local government and civil-society organizations, and a member of the injecting community now sits on the District AIDS Coordination Committee.

www.nayagoreto.org.np

Source: *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations–2016 update*. Geneva: World Health Organization; 2016.

Because of the widespread and punitive laws used against people who inject drugs, safeguards must be built into partnerships to ensure that people who inject drugs do not face criminal sanctions for organizing, do not fear that identifying themselves will lead to exclusion from social services or employment and other forms of harassment, and do not experience further stigmatization or denial of service from health-care providers. Among other things, this means that partners in community empowerment should be prepared to advocate for the replacement of punitive environments and processes with ones that are supportive and inclusive of people who inject drugs. For more information on community-led drug policy advocacy, see the Australian Injecting & Illicit Drug Users

League (AIVL) research report, *The involvement of drug user organisations in Australian drugs policy* (2014).

Box 1.5

Ten principles for meaningful engagement in drug policy

1. Human rights should underpin all drug policy and the meaningful engagement of people who inject drugs in the drug policy process.
2. Processes of meaningful engagement between organizations of people who inject drugs and policy agencies should commence from the beginning of the policy process rather than part way through it.
3. Acknowledge the expertise of people who inject drugs and their organizations: this expertise should be given equal respect, recognition and priority within the policy process as other forms of expertise or experience.
4. Engage with a broad range of communities affected by drug policies, including a recognition of the diversity of people who use illicit drugs, and acknowledge and respond to changing drug use patterns.
5. People who inject drugs and their organizations must be properly supported to participate in a meaningful way in drug policy. This includes proper resourcing and funding, training, support and mentoring for drug-user representatives engaged in the process, sufficient timelines to support meaningful engagement, and guidelines on patterns of engagement.
6. Open communication among all stakeholders is important, including genuine willingness to compromise, and transparency in the policy process.
7. There is a need for a commitment to genuine engagement rather than tokenistic representation of people who inject drugs and their organizations in drug policy.
8. Recognize that organizations of people who inject drugs are under-resourced for policy and advocacy roles, and therefore need adequate time to respond properly to new and revised policies that affect the lives of those they represent.
9. Understand and accept that organizations of people who inject drugs have a responsibility to act as powerful advocates on behalf of their constituents without being characterized as “difficult”, unwilling to compromise or unrealistic about political imperatives.
10. Representatives of organizations of people who inject drugs should commit to acting in a respectful, open and professional manner when representing their community in policy forums. At the same time, it must be recognized that representatives often expose themselves to personal risk by publicly identifying as persons who injects drugs and engaging in policy activity.

Adapted from: 10 principles of meaningful engagement in drug policy. Canberra: Australian Injecting & Illicit Drug Users League (AIVL); 2012.

1.2.2 Fostering outreach and service provision led by people who inject drugs

There is a difference between outreach programmes that are *done for* people who inject drugs and those *done with or led by* people who inject drugs (Table 1.1). Initiatives done with or led by people who inject drugs operate under the principle that people who inject drugs are best equipped to help each other learn not only to protect themselves from risks to their health and safety, but also to promote and protect their human rights, and to seek redress when their rights are violated. People who inject drugs should therefore be a strong force in programmes addressing HIV and HCV. It is not enough to “consult” with people who inject drugs before creating a programme. Rather, programmes should be based on the needs, perceptions and experiences of people who inject drugs, who should be meaningfully involved in the design of programmes from the outset, and their implementation and evaluation.

Table 1.1 Comparison of programme approaches from a community empowerment perspective

PROGRAMMES DONE FOR PEOPLE WHO INJECT DRUGS	PROGRAMMES DONE WITH/LED BY PEOPLE WHO INJECT DRUGS
Often assume that knowledge and power reside with the programme staff and managers.	Programmes focus on the collectively identified needs of people who inject drugs and develop appropriate solutions. People who inject drugs are engaged in all stages of planning and implementation.
Involve people who inject drugs in programme implementation often as volunteers, or in low-paid positions, not as equal partners.	Involve people who inject drugs as equal partners in programme implementation, more commonly as paid employees or as peer outreach workers working with the community.
Monitoring focuses primarily on goods and services delivered and targets to be achieved.	Monitoring focuses primarily on quality of services and programmes; their accessibility and acceptability to people who inject drugs; community engagement; adequacy of service coverage; and responsiveness to the changing locations and needs of people who inject drugs.
Focus on building relationships within the health system with health-care providers. Less emphasis is placed on building relationships among groups of people who inject drugs.	Focus on building relationships within communities of people who inject drugs as well as between people who inject drugs and other organizations, service-providers, human-rights institutions and similar groups.

Fostering outreach led by people who inject drugs requires that non-community service-providers support organizations of people who inject drugs in becoming partners in service provision. It is important to employ educators and outreach workers who are themselves current or former injecting drug users in order to ensure the trust and confidence of service recipients (see Chapter 4, Section 4.4). However, people who inject drugs should not be limited to these roles in community-based programmes, but should have the opportunity to participate at all other levels of the programme, including decision-making on programme implementation, management and governance. Capacity-building and mentoring should be a priority to enable people who inject drugs to take up these leadership positions (see Section 1.2.5).

Box 1.6**Community-led and community-based organizations**

It is crucial to note that community-led organizations (i.e. those led by and for people who inject drugs) are not the same as generic community-based organizations (CBOs). In community-led organizations, power and decision-making lie in the hands of community members—i.e. people who inject drugs—whereas in a CBO (which may be a local affiliate of a national or international NGO), power may reside only with some members of the community, or, more commonly, with administrators who are not community members.

It is the self-determining and self-governing nature of an organization, and its commitment to pursue the goals that its own members have agreed upon, that makes it a genuinely community-led organization.

1.2.3 Adapting to local needs and contexts

HIV and HCV programmes must be sensitive to the diversity of cultures of people who inject drugs and respond to different drug use patterns and the needs and priorities of the local drug-using community. What it means to be a part of this community varies considerably according to social class, ethnicity, language, gender and race. Drug laws disproportionately affect the most marginalized and oppressed sectors of the drug-using community: in different settings these may be women, ethnic minorities, migrants and mobile workers, men who have sex with men, sex workers, prisoners, transgender people, the young or the poor.

Flexibility, responsiveness and adaptability are essential in implementing community empowerment initiatives. Intervention goals need to remain aligned with the needs of people who inject drugs, even if these change over time.

1.2.4 Developing organizations of people who inject drugs

Community-led organizations and networks have an important role in institutionalizing support for people who inject drugs and empowering communities to lead their own responses. Forming any type of group of people who inject drugs will be more successful if the process is initiated and led by the community, which gives communities a sense of ownership. A common first step in developing community cohesion is providing or identifying a space (such as a drop-in centre) where people who inject drugs can come together to socialize and discuss common issues (see Box 1.7). This helps them break down the internalized stigma and isolation common among people who inject drugs, and creates shared community norms and values.

People who inject drugs may also come together over issues that affect them individually but that require a group response, such as addressing violence, extortion and harassment; overdose and overdose deaths; responding to contaminated batches of street drugs or unscrupulous sellers; needs for child care; or seeking information as new (and frequently undocumented) migrants. Groups are likely to function most effectively when communities decide collectively on priorities for the whole group, agree on a process for making decisions, and on a common set of rules for being together as a group.

Box 1.7

Bringing people who inject drugs together

- Organize group activities at safe spaces (which may be drop-in centres, but might also be members' homes, community centres, church rooms or other public facilities) based on the interests of the group members.
- Plan activities for special occasions, such as festivals, holidays or commemorative days.
- Invite recognized community activists or peer outreach workers from neighbouring areas to speak at a gathering of local people who inject drugs.

A strong community-led organization is characterized by vibrant membership, increasing financial independence and political power, and broadening social engagement. However, not all groups of people who inject drugs will become independent organizations. Some groups deliberately choose the independence that comes with not being funded, and this can foster a dynamism and flexibility lacking in groups tied to funded work plans and donor objectives or imperatives.

If a community-led group decides to establish itself as a formal organization, it is important to develop a clear plan for its size, geographic reach, types of activities etc. Mission and vision statements,¹ together with a strategy statement or strategic plan, help an organization to:

- **Create a clear understanding of what it wants to accomplish:** for example, if the community wants to be involved in advocacy for legal reform or policy issues, forming or joining a network of like-minded groups may be the most effective approach. If it wants to provide services directly to other community members, forming an organization (which may eventually become legally registered) may be more appropriate.
- **Establish a framework for how it will achieve its vision:** this requires understanding the steps needed and resources available for forming the kind of group that best fits the community's vision.
- **Describe clearly the mechanisms (roles/responsibilities) to reach its goals:** although these may only go into effect once the network or group has been formed, it is important to have some idea of what will be needed so that the members can assess whether they are prepared to take on the responsibilities.

Forming a registered organization

Depending on a group's size and goals, as well as the country in which it is forming, it may decide to become a legally registered entity. The process to do this varies from country to country. Group members may need to:

- understand the legal requirements (e.g. becoming a legal entity) so that funding opportunities and tax requirements/exemptions can be addressed
- establish full-time, part-time and volunteer positions for management and operations or service delivery

¹ Organizations summarize their goals and objectives in mission and vision statements. A mission statement describes what an organization wants to do *now*—its focus, critical processes and desired level of performance. A vision statement outlines what an organization wants to be *in the future*. It is a source of inspiration and motivation, sometimes looking at broader society and describing the change that the organization wants to effect.

- establish clinical oversight, if a clinic is part of the service offered
- establish advisory bodies and connect with relevant existing organizations to maximize opportunities for networking, support and mentoring
- identify and manage funders and associated contractual obligations. Funding may come from one source or a mix of government, development partners, private institutions, corporate bodies, philanthropic organizations etc.

The necessary registration materials must be obtained from the relevant government office. Precise requirements for documentation are set out by each government. Examples of the types of documentation required are:

- memorandum of association, by-laws, constitution and charter
- report of annual activities
- financial reports/audit reports
- summary of organizational resources
- organizational chart/staffing plan (and human resources manual, if available)
- board of directors and rules and regulations governing the board (board endorsement of registration is also needed)
- board of trustees with registered charitable status, deed and rules of governance including the beneficiaries of the Trust
- letters of support from key partners.

Some of these documents may not be available for organizations just starting up and may need to be developed.

Most countries have NGO coordinating bodies that offer advice or guidance on forming an organization. Organizations of people who inject drugs in neighbouring countries, or regional networks of such organizations, can also often provide advice and support on dealing with registration and overcoming the barriers that face people who inject drugs registering their own organizations.

Networks

If the organization finds the requirements too complex or difficult to meet, it may be possible to register as a member of a network. This may be an appropriate intermediate step for a nascent organization on its way to registration, giving it the protection and support of the network as it grows and develops the materials needed for individual registration.

National networks of people who use drugs have been established in many countries, including in challenging environments such as Afghanistan. In the absence of national networks, groups can affiliate with regional or global networks such as the International Network of People Who Use Drugs (INPUD). There are networks of people who use drugs in each region. Similarly, there are regional networks of AIDS service organizations with which groups or national networks could affiliate.

1.2.5 Strengthening organizations and building capacity

Organizational capacity-building is a comprehensive approach to strengthening an organization's ability to plan, manage and finance itself so that it can implement its own vision and strategy. Capac-

ity-building can help organizations led by people who inject drugs to become resilient, self-sufficient and respected as equal partners at the policy table. Capacity-building is also important to create an organizational structure that provides consistency over time and establishes processes for succession planning, ensuring that community-led programmes continue. Lastly, capacity-building also helps the organization deliver on indicators and targets required by funders. Whether organizations of people who inject drugs are already established, or whether they come into being as a result of HIV and HCV prevention programming, it is important for them to understand the goals and needs of funders, while developing the ability to shape those goals where necessary to ensure that they do not conflict with the organization's own vision.

Like other organizations, organizations of people who inject drugs face varying challenges to becoming stronger and more sustainable, and they benefit from different approaches. An established organization may have a good understanding of its community's needs and be able to lead the process of capacity-building without outside facilitators. A recently formed organization may need more guidance, but certain principles apply to capacity-building in general. Support should be:

- **Comprehensive:** Acknowledging all the capacity-building needs of an organization makes it possible to design a systematic approach to address all the essential needs, e.g. service provision, procurement, advocacy, programme management, M&E, governance, and resource mobilization.
- **Contextualized and customized:** Support should take account of the organization's particular cultural, political and social environment.
- **Locally owned:** Persons providing capacity-building support may understand the processes and can help identify needs. However, if the organization is not making its own decisions, capacity-building efforts will not be as successful.
- **Based on the organization's current abilities:** The type, level and amount of capacity-building should be based on the organization's ability to absorb and use the resources (financial and nonfinancial) being offered.
- **Oriented both inward and outward:** While it is essential for an organization to ensure the health of its staff and internal structures, it is also important to remember that any organization is part of a larger community and needs to understand opportunities for partnership and the potential benefits of external links.
- **Sustainability-based:** Capacity-building should strengthen an organization's ability to maintain a base of financial resources so that it may continue to function well.
- **Learning-focused:** An organization that does not continue to learn about its functions, its community, the wider community and technical areas will become stagnant and cease to be relevant.

Whether an organization of people who inject drugs is a legally registered NGO or not, capacity-building can present specific challenges:

- Stigma, discrimination and the illegality of drug use can make it hard to engage people who inject drugs in roles that demand time and a certain level of publicly visible activities.
- Organizations staffed by people solely on the basis that they use drugs may initially lack the full range of managerial and technical skills needed to function optimally.
- Aspects of the lifestyle of people who inject drugs (including drug dependence) may make it difficult to retain staff and maintain optimal consistency within the organization.

To deal with missing skills, some organizations outsource certain functions, such as financial management, to organizations that provide this service. One way to mitigate the loss of staff is to have more people involved in organizational activities, so that there is a larger number with institutional memory. This is especially important to facilitate smooth transitions.

Organizations can build their capacities in specific areas. A best practice in preparation for this is for an organization to undergo a capacity assessment. There are many tools for this, including self-assessments, although a good, externally facilitated assessment helps an organization bring out issues it might not identify itself. The assessment provides the organization with a capacity-building plan to address areas identified for improvement. Box 1.8 summarizes areas of organizational capacity-building, and these are explored in more detail below.

Box 1.8

Strengthening organizational capacity

Governance

- Develop a strategic plan to guide programming that reflects the organization's vision and mission. Reassess goals and objectives regularly.
- Create a fair and transparent method for making decisions that includes staff (if the organization has them) and other members of the organization.
- Establish processes to manage change and seek new opportunities for action.

Project management

- Ensure that the process for carrying out and managing activities is participatory, transparent and has accountability, and that information is shared promptly across the organization.
- Identify skills needed and organize training to build capacity of members in programming, human resources, financial management, advocacy etc.
- Introduce mentoring and support systems to enable sustainability, and leadership succession planning and to safeguard against burnout.

Resource mobilization

- Build knowledge of funding sources and develop grant-writing skills.

Networking

- Encourage cooperation and learning from other organizations and networks of people who inject drugs, nationally and internationally.

Governance

Good governance means the responsible management of an organization's strategic vision and resources. Transparency, accountability and effective management are essential components of good governance and of an organization's ability to meet its mandate.

A board gives strategic direction, provides support in legal affairs and accounting, and protects the organization. The board should combine expertise and appropriate representation. In the case of organizations of people who inject drugs, a board may include allies with the connections and influence to advocate to reduce the stigmatization faced by people who inject drugs, and to help with fundraising. The size of a board is less important than their demonstrated commitment to the organization's cause and to helping establish and grow the organization.

Project management

Well-managed, technically sound programmes and projects not only ensure that organizational objectives are achieved, but also instil confidence in donors and key stakeholders about the competence of the organization. An organization is on the right track if it:

- develops and follows realistic work plans and budgets that are in line with its vision and mission
- defines technical interventions that are in line with local and international good practices
- ensures that its programmes and projects are responsive to the needs of its members.

Resource mobilization

Organizations should always be engaged in resource mobilization to fund efforts on a long-term basis. It is important to be strategic and look beyond the short term, especially if the organization is currently benefitting from a grant that will end after several years. While there is no guarantee that an organization will be able to raise money, there are good practices that may help. Important issues to consider with respect to resource mobilization include:

- Is the resource mobilization strategy in line with the organization's vision and mission?
- Can resources be raised from members of the organization, i.e. through a small monthly or annual membership fee? This increases a sense of ownership, but the sum should not be so high as to exclude people from joining. A scaled membership fee may be considered.
- Are there government schemes that may be able to fund specific activities or programmes (without imposing an agenda that conflicts with that of the programme)?

Developing partnerships

Developing a strong, successful organization of people who inject drugs is as much about relationships as it is about systems. Networking involves donors, communities, and national- and local-levels government, service-providers and NGOs. The organization must learn to engage and influence, focusing on the principles of justice and empowerment. Some of the functions of networking are ensuring human rights, securing comprehensive services for clients and developing relationships with donors (see Section 1.2.7).

Two areas of networking that are especially important for organizations of people who inject drugs are engagement with state institutions and structures, such as policy-makers, law enforcement, health and social services and entitlement programmes; and engagement with non-state organizations and institutions. Examples of issues that can be addressed through networking include institutional discrimination against people who inject drugs and biased media portrayals of them.

Engagement with governmental organizations: This is particularly important to enable programmes for people who inject drugs to advocate for access to health services, freedom from discrimination and harassment, protection from and redress for violence, and securing rights and entitlements as citizens. A partner organization working with the organization of people who inject drugs may have connections to enable members of community-led groups to join committees that oversee health programmes, or provide access to politicians and other officials. Capacity-building may help guide people who inject drugs who are unfamiliar with formal meeting processes, or with protocol for dealing with officials, enabling them to learn how to participate and engage effectively.

Engagement with nongovernmental organizations and institutions: Fostering partnerships with allies is an important aspect of capacity-building. It helps to establish an organization of people who inject drugs as a legitimate community with valid aims and objectives. Building links with other organization also helps identify a network of service-providers that can meet the needs of people who inject drugs more holistically. Such networking includes:

- other community-led and community-based organizations and NGOs
- community-led networks and organizations of sex workers, men who have sex with men, transgender people, young key populations, and people living with HIV
- local women's organizations, faith-based organizations and other community groups or relevant organizations with a focus on gender-based violence, human rights, access to health, access to justice, adult education and skills-building, and a range of other social issues and entitlements.

In each case, organizations of people who inject drugs should seek allies that value their input and see them as a partner, rather than a beneficiary. This means that the organizational allies should be respectful, supportive, and serious about meaningful engagement.

1.2.6 Shaping policy and creating enabling environments

Community empowerment processes can reach beyond the community to influence policy and create enabling environments through advocacy. This involves community organizing, educating policy-makers, raising public awareness, documenting the lived experiences of community members, training, demonstrations, litigation and lobbying, as well relationship-building and forming networks. Advocacy can use communications strategies including mainstream media and Internet-based communication technologies such as social media to issue public statements or raise awareness.

Advocacy designed to influence law and policy must consider the safety and security of community members. This includes protecting the confidentiality of individuals and data collected for advocacy purposes. Programmes serving people who inject drugs should have safety and security protocols in place to respond quickly to violence, blackmail, arbitrary arrest or other harassment.

Box 1.9

Case example: Organizing to shape government policy in Indonesia

Persaudaraan Korban Napza Indonesia (PKNI) is a national network of organizations of people who use drugs. Established in 2006, PKNI has grown from a loose arrangement of support groups scattered across 11 provinces to an independent, leading national network representing the common priorities of 25 self-organized drug user groups across 19 provinces.

PKNI empowers Indonesia's drug-using community to adopt safer injecting practices that reduce HIV and other bloodborne virus transmission, to understand the country's drug laws and their rights, and to articulate their needs and experiences to policy-makers, service-providers and donors through reports, presentations, policy reviews and community-based research.

PKNI has provided an important platform for the voice of the drug user community within the national response to HIV. In 2014, PKNI partnered with Indonesia's Ministry of Health to develop its national harm reduction guidelines to ensure that the needs and rights of people who use drugs were accommodated. This was the result of a two-year process of sustained advocacy. Based on the findings of a 2013 quality monitoring and control survey, PKNI advocated for the inclusion of people who use drugs in the pre-consultations and negotiations around the harm reduction guidelines. PKNI built relationships with government officials and ministries, eventually obtaining a seat on the National Harm Reduction Taskforce.

Community members now have the opportunity to shape policy processes, monitor and evaluate the effectiveness of the national HIV programme for people who inject drugs from the community's perspective, and engage in strategy for reducing HIV among people who use drugs.

<http://korbannapza.org/en>

1.2.7 Sustaining the movement

Funding community-led organizations of people who inject drugs is now widely recognized as central to an effective HIV response and is specifically recommended by the Global Fund in its *Key populations action plan 2014–2017* and by the World Health Organization in the 2016 *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations*. It is unreasonable to expect any group to grow from a small collection of individuals to a movement whose members actively contribute to the national HIV response unless it receives sustained support and its participation is welcomed. It is therefore essential that governments, national partners and development partners actively support the establishment and sustainability of organizations and networks led by people who inject drugs. Social contracting is key not only to sustaining movements of communities of people who inject drugs, but also to an effective and sustained HIV response, and thus it is an essential part of a government's efficient allocation of its resources.

Box 1.10

**Case example: Community advocacy
for improved OST in Australia**

A number of consumer representatives sit on the Opioid Treatments Advisory Committee of the Australian Capital Territory (ACT). Staff from the Canberra Alliance for Harm Minimisation and Advocacy (CAHMA) and from The Connection, an organization of people who use drugs, participate in the advisory committee, along with two consumers from the community chosen by CAHMA's peer-support group PHAAT (Pharmacotherapy Advocacy Action Team).

In 2009–2010 the ACT undertook a review of its pharmacotherapy guidelines. The consumer representatives argued for greater flexibility, more respect to be shown for consumers within treatment settings and better mechanisms for dispute resolution. The methods used to influence change in this policy area included consumer consultations to identify priority issues; regular PHAAT meetings to strategize; research into national guidelines and other policy documents; and representation of the issues at the Advisory Committee meetings. The ACT guidelines were improved as a result.

Source: The involvement of drug user organisations in Australian drugs policy: a research report from AIVL's 'Trackmarks' project. Canberra: Australian Injecting & Illicit Drug Users League (AIVL); 2012.

Funding support should not, however, be tied to donor-driven approaches that may conflict with the needs and priorities determined by the community. Flexible approaches that are based on genuine and open communication, and therefore more responsive to community needs, are more likely to lead to more effective outcomes. Furthermore, heavy and restrictive reporting requirements often place a high burden on organizations that are understaffed and inadequately resourced. Quantitative targets may not capture the nuance and complexity of the work of community-led organizations, and what counts as success on the ground in the eyes of the organization may differ from the viewpoint of the donor. This risk can be mitigated—and more productive funding strategies negotiated—if the community empowerment process has progressed to the stage where decision-making power is vested within the community-led organization.

The extreme marginalization of people who inject drugs makes it particularly challenging to sustain community-led organizations and networks, and unless this marginalization is recognized and addressed, no community empowerment approach will be successful or even conceivable. Organizations of people who inject drugs should try to operate in solidarity with other social movements, particularly those that also advocate for human rights. This may include movements of other key populations with similar experiences of heightened HIV risk and social exclusion—such as sex workers, men who have sex with men, transgender people, and prisoners or former prisoners (many of whom are also people who inject drugs)—as well as organizations and networks of people living with HIV and HCV. Collaboration between movements can be difficult while the stigma attached to drug use continues to be very strong, but ultimately it can strengthen the collective response to HIV and ensure that communities are at the centre of that response.

Box 1.11

Case example: Supporting communities through a regional harm reduction network in Eastern Europe and Central Asia

Low-threshold grants programmes that make funding available to small, new or not even formalized organizations of people who use drugs who want to make positive change in their communities have repeatedly shown significant impact. The Eurasian Harm Reduction Network, with support from the Robert Carr Civil Society Networks Fund, initiated a small-grants programme in 2013, through which it disbursed 25,750 Euros (approx. USD \$33,000) to seven organizations in Armenia, Georgia, Latvia, Moldova, the Russian Federation, Tajikistan and Ukraine. Projects were implemented by groups of people who use drugs to mobilize, document and respond to human-rights violations, and to evaluate and improve the quality of harm reduction programming, applying their particular motivation and knowledge to improving the communities they live in. Each project received technical support from EHRN and benefited from its capacity as a regional network uniting professionals, activists and representatives of the community of people who use drugs.

Apart from the particular gains achieved by each project in their individual countries, EHRN found there were benefits common to all of them:

- The particular expertise and knowledge of people who use drugs was applied to improve health and human-rights outcomes.
- People who use drugs showed they can be a driving force behind policy reforms that bring their countries into line with international standards.
- EHRN made space for groups from different countries to learn from and inspire each other.
- People who use drugs felt the impact of their work, and all groups supported by the programme continued with sustained advocacy work.
- The project showed people who use drugs concrete examples of positive change that they can bring to their communities.

Source: [People who use drugs making meaningful change](#). Vilnius: Eurasian Harm Reduction Network (EHRN), 2014.

Despite political, legal and financial challenges, it remains essential to mobilize resources and build political commitment for community-led organizations, and this approach has had positive results. Community advocates must be respected partners in policy-making, irrespective of the legal status of drug use. A strong, healthy and vibrant civil society working in genuine partnership has been the backbone of the HIV response for 30 years. As we move forward, organizations and networks of people who inject drugs should be core members of this partnership.

Box 1.12

Case example: Broadening the range of allies and partners in a campaign in Eastern Europe and Central Asia

The Eurasian Harm Reduction Network's (EHRN) regional advocacy campaign “Women Against Violence” aims to stop police violence against women who use drugs. The campaign is being implemented with partners from 16 cities in Belarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova, the Russian Federation and Ukraine. EHRN enlisted 18 partner organizations in the campaign, which began in March 2014. Most of these were organizations providing harm reduction services with which EHRN had already cooperated on issues of gender and drug use. EHRN signed a memorandum of cooperation with each of the organizations so that they would have a sense of ownership of the campaign. This was important to keep partners motivated to pursue activities at the local level (especially since the campaign had no central budget). The memorandum gave clear details of responsibilities, of the support that EHRN would provide, and of the expectations of what the organization would do.

During the first year of the campaign, the partner organizations collected details of more than 805 cases of police violence through a specially designed online platform. They then organized roundtable discussions with law-enforcement representatives and other stakeholders, including a human-rights advocacy organization, health-ministry representatives, a lawyers' association, and a private law firm that offered pro bono services. Partners signed memorandums of cooperation with police departments and organized trainings on harm reduction and the rights of women who use drugs. This led to the formation of a network of cooperative law-enforcement representatives, and EHRN has since participated in international conferences on law enforcement and public health, and on criminal justice.

At the same time as expanding its network of allied organizations and institutions and advocating for an end to violence against women who use drugs, EHRN and its partners have learned more about how police officers think and work, and how the criminal justice system is organized, enabling them to strategize better to help women manage legal systems within their countries.

Source: [Women against violence](#). Vilnius: Eurasian Harm Reduction Network (EHRN); 2014.

1.3 Monitoring progress

The progress of community empowerment can be documented, to inform and improve upon community-led or community-based programming. Short- and long-term objectives and goals should be established to guide community empowerment, and related indicators should be used to measure outcomes and impact. As an example, monitoring community empowerment in relation to HIV and HCV prevention, treatment, care and support and health services would measure the involvement of people who inject drugs in each of the following: how services are run, quality assurance, funding allocations, training of health personnel to address stigma, and advocacy to address discrimination—rather than simply whether a target percentage of people who inject drugs has accessed a particular service.

Communities can also monitor the progress of their success towards improving and shaping the services that they receive. Organizations of people who inject drugs should set the measurement

parameters in partnership with national policy-makers and programmers to monitor and evaluate programmes at all stages.

Special attention must be paid to ensuring that doubly marginalized sectors of the drug-using community (see Section 1.2.3) are included. The use of qualitative research and narratives to tell complex stories of community empowerment are particularly valuable. Table 1.2 describes sample outcomes and indicators for monitoring community empowerment.

Table 1.2 Monitoring indicators for empowerment of people who inject drugs

LEVEL	EMPOWERMENT OUTCOMES	EXAMPLES OF EMPOWERMENT INDICATORS
Central	- Inclusion of people who inject drugs in policy, programming and funding decisions - Prioritization and investment in community-led HIV prevention approaches	- Number of representatives from organizations of people who inject drugs who are members of national multisectoral HIV coordinating bodies - Increase in contracts and amount of funding allocated to groups led by people who inject drugs
State/provincial level	- Increased participation of people who inject drugs in formation of state/district-level policies and programmes - Increased involvement of people who inject drugs in planning and implementation of health, legal and social services	- Number of organizations of people who inject drugs included in state/district policy and programming bodies - Number of people who inject drugs actively involved in planning and implementing health, legal and social services
District/county level	Increased knowledge of health-care providers, police and social-service agencies on rights and needs of people who inject drugs	- Number (and proportion) of health-care providers, police and social-service agents who have received training and sensitization about people who inject drugs - Attitudes and practices of health-care providers, police and social-service agents towards people who inject drugs (measured by surveys of these groups and of people who inject drugs)
Municipality/Submunicipality	- Increased awareness of the wider community about the rights of people who inject drugs - Expanded partnership between organizations led by people who inject drugs and other community groups	- Percentage of sample of people who inject drugs reporting stigma and discrimination from service-providers and from the wider community - Number of outside organizations that have partnered with organizations led by people who inject drugs
Organizations of people who inject drugs	- Increased capacity of people who inject drugs to operate in groups/organizations - Increased capacity of people who inject drugs as legal advocates to document and challenge human-rights violations	- Number of available drop-in centres for people who inject drugs - Number of organizations led by people who inject drugs - Number of public meetings, marches or rallies held to promote rights of people who inject drugs - Percentage of people who inject drugs who report participation in a group/collective of people who inject drugs - Number of people who inject drugs trained as legal advocates - Documentation of human-rights violations

Note: Some of these indicators are based on those given in the [Tool to set and monitor targets for HIV prevention, diagnosis, treatment and care for key populations](#). Geneva: World Health Organization; 2015.

1.4 Further resources

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5. Vancouver Declaration: why the world needs an international network of activists who use drugs. London: International Network of People Who Use Drugs; 2006.
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7. Tool to set and monitor targets for HIV prevention, diagnosis, treatment and care for key populations. Geneva: World Health Organization; 2015.
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14. Health systems in action: an eHandbook for leaders and managers. Cambridge (MA): Management Sciences for Health; 2010.
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2 Legal Reform, Human Rights, Stigma and Discrimination



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What's in this chapter?

This chapter offers practical advice on the human-right issues faced by people who inject drugs, especially recognizing and responding to stigma, discrimination and criminalization. It suggests approaches for legal and policy reform, and ways to monitor interventions for promoting and protecting the human rights of people who inject drugs.

2.1 Introduction

People who use drugs¹ face high levels of stigma, discrimination, violence and other human-rights violations. These include denial of health services and social services, restrictions on employment or access to education, the removal of children from parental custody, incarceration or detention without trial, coerced drug treatment (often against their will in “treatment centres”), denial or cessation of opioid substitution therapy (OST), and physical violence. Stigma, discrimination and violence are reinforced by the criminalization of drug use in most countries, and together these factors drive the HIV and hepatitis C (HCV) epidemic among people who inject drugs by preventing them from accessing lifesaving services for harm reduction as well as HIV and HCV diagnosis, treatment and care.

Principles for a human-rights based approach are listed in the introduction to this tool, since such an approach is essential to all aspects of harm reduction and HIV and hepatitis C prevention. This chapter addresses several priorities for legal reform, and some practical aspects of securing and monitoring human rights, before turning to strategies to address violence, stigma and discrimination against people who use drugs, and monitoring of programmes.

Because stigma and discrimination operate at both institutional and individual levels, the experiences and suggested practices presented in this chapter are directed at national programme-planners and policy-makers, and also at implementing organizations² working at the local level, including organizations led by people who use drugs.

2.2 Reviewing and reforming laws and policies

Laws and policies, when essentially punitive, can be major barriers to accessing services for people who use drugs. Advocacy is important for the reform of laws and policies to incorporate access to human-rights based, evidence-informed programmes, in particular needle and syringe programmes (NSPs) and OST services.

2.2.1 Frameworks for reform

Advocacy for human-rights based reform of drug laws should emphasize that international conventions on drugs do not mandate the criminalization of drug use, and that they contain flexibility that permits countries to refrain from criminalizing the possession of drugs for personal consumption. Reference can be made to rights enshrined in the International Covenant on Economic, Social and Cultural Rights (ICESCR), and the International Covenant on Civil and Political Rights (ICCPR), and other relevant core human-rights treaties, especially to specific clauses such as:

- the right to the highest attainable standard of physical and mental health (ICESCR, Article 12)
- the right not to be subjected to torture or other cruel, inhuman or degrading treatment or punishment (ICCPR, Article 7; Convention Against Torture, Articles 2 and 16)
- the right to nondiscrimination (ICCPR, Article 2; ICESCR, Article 2).

1 Drug use refers to the nonmedically sanctioned use of psychoactive drugs, including drugs that are illegal, controlled, or prescription.

2 An implementing organization is an organization delivering an intervention to people who inject drugs, with a client-centred approach. It may be a governmental, nongovernmental, community-based or community-led organization, and may work at a state, provincial, district or local level. Sometimes a nongovernmental organization provides services through subunits at multiple locations within an urban area, and in this case, each of those subunits may also be considered an implementing organization.

The United Nations (UN) 2016 General Assembly Special Session on the World Drug Problem Outcome Document³ has a specific emphasis on human-rights, gender- and health-focused responses, including to:

- encourage the voluntary participation of individuals with drug use disorders in treatment programmes, with informed consent (paragraph 1(j))
- ensure nondiscriminatory access to health, care and social services in prevention, primary care and treatment programmes, including those offered to persons in prison or pre-trial detention (paragraph 4(b))
- encourage the development, adoption and implementation ... of alternative or additional measures with regard to conviction or punishment (paragraph 4(j))
- promote and implement effective criminal-justice responses to drug-related crimes to ensure legal guarantees and safeguard due process, including practical measures to uphold the prohibition of arbitrary arrest and detention and of torture and other cruel, inhuman or degrading treatment or punishment and to eliminate impunity, in accordance with relevant and applicable international law and taking into account UN standards and norms on crime prevention and criminal justice, and ensure timely access to legal aid and the right to a fair trial (paragraph 4(o)).

For further information on the relationship between criminalization of drug use and human-rights violations, see the [INPUD consensus statement on drug use under prohibition: human rights, health, and the law](#) (2015).

Box 2.1

A framework for legal review

The Canadian HIV/AIDS Legal Network published a series of [eight modules](#) in 2006 for review of laws on drug use in the context of HIV prevention. These model laws are useful tools to propose and advocate for reforms. Each module starts with a rationale and proposes models that are in line with human rights, addressing:

- Criminal law reform
- Treatment for drug dependence
- Sterile syringe programmes
- Supervised drug consumption facilities
- Prisons
- Outreach and information
- Stigma and discrimination
- Heroin prescription programmes

The modules provided a framework for a legal review conducted in six Central Asian countries in 2010. For more information, see [Accessibility of HIV prevention, treatment and care services for people who use drugs and incarcerated people in Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan: legislative and policy analysis and recommendations for reform](#). Toronto (ON): Canadian HIV/AIDS Legal Network; 2010.

3 [Our joint commitment to effectively addressing and countering the world drug problem](#). Outcome document of the United Nations General Assembly Special Session on the World Drug Problem. A/RES/S-30/1. New York (NY): United Nations; 2016.

Box 2.2

Case example: Reforming drug law through a consultative process in Myanmar

As part of a comprehensive effort to respond to drug use in Myanmar, in 2015 the United Nations Office on Drugs and Crime (UNODC) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) supported a consultation on amending Myanmar's Narcotic Drugs and Psychotropic Substances Law. The objectives of this workshop were to present proposed amendments to the drug law and receive technical guidance and input from participants.

The workshop, held by the Central Committee for Drug Abuse Control, involved a broad range of stakeholders, including senior representatives of government, parliamentarians, international health and legal experts, international and local nongovernmental organizations (NGOs), drug-user networks, development partners and UN agencies. Participants suggested crucial changes, such as removing compulsory registration for drug users, switching from imprisonment to drug treatment, reducing penalties for minor offences and including the harm reduction approach in the law. Recommendations were also made by the UN to remove the death penalty for drug-related criminal offences.

UNODC is now supporting three rounds of consultations organized by the government and including civil-society groups to draft a National Drug Control Strategy. The technical inputs provided by UNODC for the strategy are aligned with the suggestions made during the consultation on the drug law. Once the strategy is finalized (probably in March 2017), the draft law will be submitted to parliament for ratification.

2.2.2 Removing criminal sanctions for drug use and drug possession for personal consumption

In recent years, a few countries have experimented with drug policy reforms, including regulations, largely focused on cannabis. While these policy changes are yet to be evaluated, Portugal's experience confirms that alternatives to criminalization of drug use lead to positive outcomes in terms of health and public safety (see Box 2.3).

2.2.3 Abolition of the death penalty

Many countries have reformed their penal codes to eliminate the death penalty, but of the 58 that retain capital punishment as of 2016, some 32 countries or subnational jurisdictions allow it to be applied to drug-related crimes. In 2007, the UN General Assembly adopted a resolution (A/RES/62/149) calling upon all states that still maintain the death penalty to establish a moratorium on executions with a view to abolishing the death penalty.

There is no evidence that the imposition of the death penalty for drug-related offences has contributed to reductions in drug use or the drug trade. As a UN entity, UNODC also advocates for the abolition of the death penalty, as does the International Narcotics Control Board. At the 2014 and 2015 high-level sessions of the UN Commission on Narcotic Drugs, numerous member states, including a number of countries from the global south, expressed their support for elimination of capital punishment for drug-related offenses.

For states that are not party to the Second Optional Protocol to the ICCPR, the imposition of the death penalty per se is not prohibited by international law. The ICCPR itself, however, limits it to use only for the “most serious crimes”. These are widely interpreted as intentional crimes with lethal or other extremely grave consequences for humanity as a whole.

Box 2.3

Case example: Portugal’s experience

Since 2001 Portugal does not criminalize any drug use. People who use drugs remain subject to administrative charges that usually result in a referral to a regional Commission for the Dissuasion of Drug Addiction (CDT in Portuguese). CDT members are health, legal and social-work professionals whose chief goal is to assess health risks and provide people who use drugs with access to as wide a spectrum of services as they need or choose to access. CDTs suspend most cases referred to them, effectively leaving most “offenders” without penalty, and offer harm reduction interventions, various drug-treatment options, and social integration and job placement programmes.

Portugal’s drug use is below the European average and has declined among 15–24-year-olds—the population most at risk for drug use initiation. The incidence of HIV and viral hepatitis have demonstrated downward trends in the last decade, due to the combined effects of a supportive drug policy and significant investments in harm reduction.

2.2.4 Young people: advocating for removal of age-related barriers

Despite the sometimes young age of initiation into injecting drug use in many countries, young people who use drugs⁴ find it difficult to obtain information, sterile injecting equipment, drug-dependence treatment, including methadone treatment for opioid dependence, and HIV testing, counselling and treatment. Age restrictions or requirements for parental consent make needle and syringe services, opioid substitution treatment and HIV testing less accessible to young people, increasing their vulnerability to HIV.

Considerations for legal and policy reform include:

- Examine current consent policies to consider removing age-related barriers and parent/guardian consent requirements that impede young people’s access to HIV and sexually transmitted infection (STI) testing, treatment and care.
- Include relevant programming specific to the needs and rights of young people who use drugs in national health plans and policies, with linkages to other relevant plans and policies, such as those pertaining to the child-protection and education sectors.

⁴ Young people who use or inject drugs are those in the age range 10–24 years, in accordance with the Interagency Working Group on Key Populations *HIV and young people who inject drugs: a technical brief* (Geneva: World Health Organization; 2015).

For further information on young people who inject drugs, including programmatic considerations for ensuring their human rights and access to appropriate services, see the World Health Organization (WHO) technical brief *HIV and young people who inject drugs* (2015).

2.3 Advancing human rights

2.3.1 Access to justice: organizing legal aid programmes and legal empowerment of people who use drugs

Legal literacy and legal aid are essential elements to ensure that the right of people—including people who inject drugs—to access justice are respected. For people who inject drugs, poor awareness of one's rights, and the inability to access legal aid in a timely manner, can result in police abuse, prolonged detention, denial of access to adequate health and social services, disputes related to child custody, breach of confidentiality, coerced abortion (see Section 2.3.6) and workplace discrimination.

Even where the right to legal aid is supported by a country's legal system, access to high-quality counsel for people who use drugs and are accused of crimes may be severely restricted due to their marginalization and economic disadvantage. People who use drugs are also frequently unaware of their rights; many cannot afford counsel or do not know how to access free legal aid. Ensuring legal literacy and adequate and timely provision of legal aid should be a high priority for government and for civil-society organizations to ensure access both to justice and to a range of other services for people who use drugs.

The responsibility of states to provide legal aid to people in the criminal justice system, including people who use drugs and people living with HIV, has been recognized in the *United Nations principles and guidelines on access to legal aid in criminal justice systems* (2012). The right to legal aid is also established by a range of international treaties, including the ICCPR.

Legal aid services can provide a variety of support to people who use drugs, including information on their rights; advice to individuals who have been detained, arrested or searched; or advice on matters related to housing, health care, child custody, education, or work-related issues. Legal aid services can include representation (oral or written) in court proceedings, and mediation of disputes. Services can be provided by lawyers (including pro bono), paralegals (Box 2.4), law students under supervision at legal clinics, or health/harm reduction workers who have been trained to deliver one or more of these services. Legal aid services may also be needed by staff working in harm reduction services, for example in cases of police harassment. Legal aid services can be integrated within harm reduction and other health services to ensure best access (Box 2.5).

Box 2.4

Case example: Paralegal services in Indonesia

In Indonesia, Persaudaraan Korban Napza Indonesia (PKNI), a network of organizations of people who use drugs, provides paralegal assistance through trained and qualified peers. Around 120 people who use drugs have been trained across eight provinces to provide paralegal assistance to their peers whose drug-related cases are presently before the courts. Paralegals give detained people who use drugs information about their rights and refer cases to lawyers. During 2013–2016, 160 cases in five provinces were supported by peer paralegals.

<http://korbannapza.org/en>

Box 2.5

Case example: Integrating legal aid and HIV services into harm reduction programmes in Ukraine

Five harm reduction organizations in Ukraine have integrated legal services into their programmes in Kyiv, Kherson, Lviv, Mykolaiv and Poltava by placing staff lawyers at locations where people who inject drugs go to pick up needles and syringes, or for counselling and referrals. The organization also provides legal services through an individual lawyer or law firm contracted by the organization. The programme has increased access to harm reduction by drawing in new clients who come for the legal services and stay for the HIV prevention services.

For more information, see *Tipping the balance: why legal services are essential to health care for drug users in Ukraine*. New York (NY): Open Society Foundations; 2008.

Where hiring a lawyer is not feasible for an organization, alternatives may include establishing relationships with law firms who can make legal aid services available pro bono and forming partnerships with civil-society organizations that work for access to justice.

Legal aid should be low-threshold and easily accessible to people who use drugs (Box 2.6).

Box 2.6

Case example:
Online legal resources in Eastern Europe and Central Asia

Navigating legal aid can be challenging for people who use drugs and for their friends and families seeking assistance and advice. hand-help.ru is an online resource that provides easy-to-understand explanations of laws and regulations on drug use in the Russian Federation. With support from the United Nations Development Programme (UNDP) and co-financing from the European Union, a [Regional HIV Legal Network](#) was established in 2012. The Network works in nine countries in Eastern Europe and Central Asia and has a system for submitting complaints online. In 2015, the Network and UNDP released a handbook in English and Russian on addressing legal issues and accessing free legal aid: *Know your rights, use your laws*.

In addition to providing legal aid to people who use drugs, giving the community⁵ the education and resources that allows them to know and understand their rights is both an empowering and transformative process that can have a significant impact on stigma and violence reduction (Box 2.7).

Box 2.7

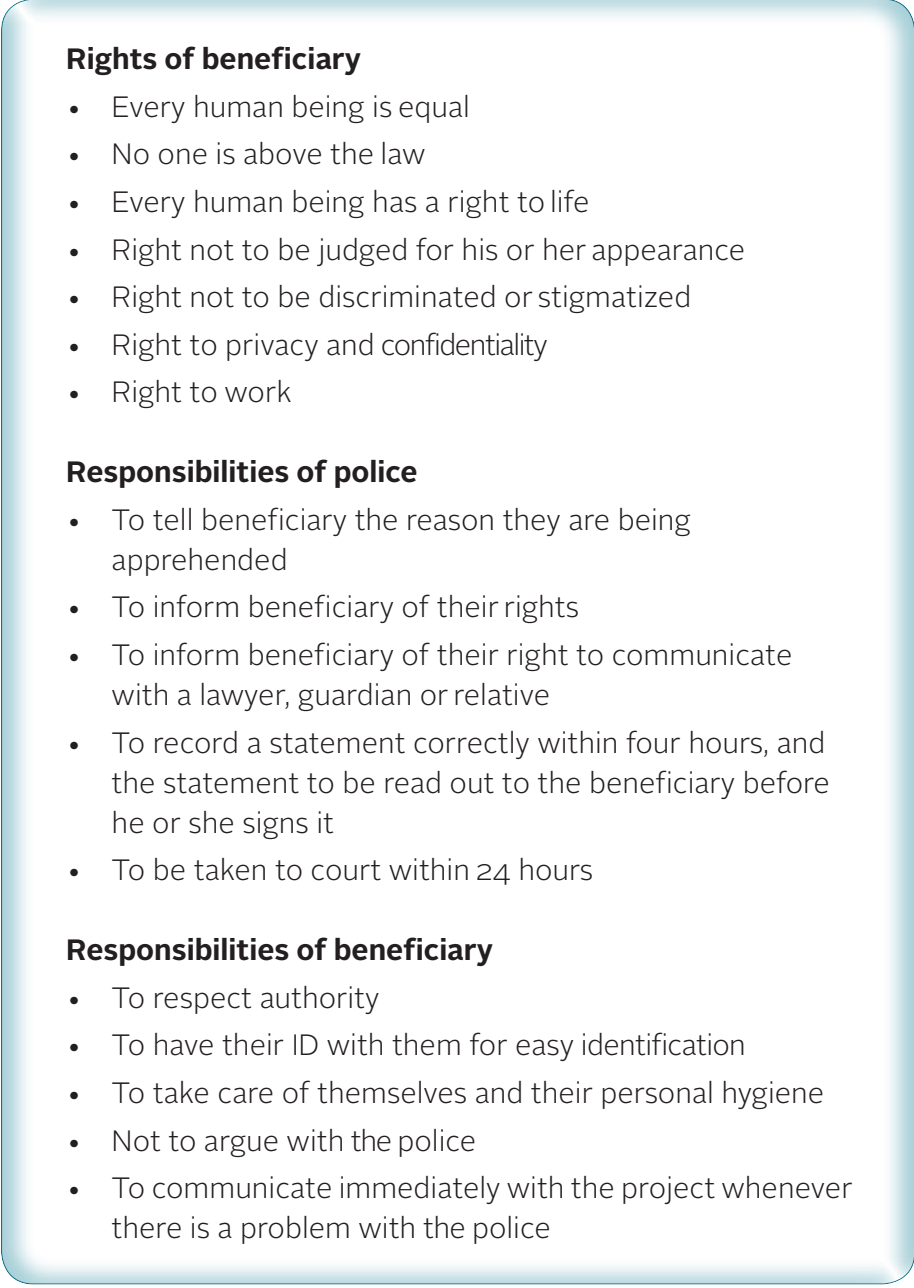
**Case example: Legal empowerment of
 people who use drugs in Tanzania and the USA**

The Tanzanian Network of People Who Use Drugs (TaNPUD) works with Médecins du Monde to train members on their rights and support them to advocate on their own behalf and on behalf of their peers. Members of the network and other participants in harm reduction programmes carry information cards to use in case of arrest, explaining their rights and responsibilities as well as the responsibilities of the police (see Figure 2.1). Anecdotal reports suggest that the police are less likely to harass people who use drugs who have the card with them. A TaNPUD crisis response team with 13 members works in different areas of Dar es Salaam and has negotiated the release from police custody of people who use drugs or helped to arrange bail from courts to prevent their pre-trial imprisonment.

VOCAL NY, a New York City-based organization, makes human rights and legal rights a regular topic of “teach-ins” for people who use drugs at harm reduction and other service or community gathering points. The teach-ins allow people who use drugs to discuss their rights with peers and have their questions and concerns addressed.

5 In most contexts in this tool, “community” refers to populations of people who inject drugs, rather than the broader geographic, social or cultural groupings of which they may be a part. People may move into or out of injecting drug use at various times in their lives but may maintain community connectedness. Thus, “community members” are people who inject drugs or people with community connectedness, “outreach to the community” means outreach to people who inject drugs, and “community-led interventions” are interventions led by people who inject drugs or people with community connectedness. For a closer definition, see Chapter 1, Box 1.1.

Figure 2.1 Know your rights card



Rights of beneficiary

- Every human being is equal
- No one is above the law
- Every human being has a right to life
- Right not to be judged for his or her appearance
- Right not to be discriminated or stigmatized
- Right to privacy and confidentiality
- Right to work

Responsibilities of police

- To tell beneficiary the reason they are being apprehended
- To inform beneficiary of their rights
- To inform beneficiary of their right to communicate with a lawyer, guardian or relative
- To record a statement correctly within four hours, and the statement to be read out to the beneficiary before he or she signs it
- To be taken to court within 24 hours

Responsibilities of beneficiary

- To respect authority
- To have their ID with them for easy identification
- To take care of themselves and their personal hygiene
- Not to argue with the police
- To communicate immediately with the project whenever there is a problem with the police

Source: Médecins du Monde, TanPUD

2.3.2 Documenting human-rights violations

Documenting human-rights violations can be an important tool to advocate for the rights of people who use drugs, to address violations more broadly or to build a court case to affect policy at national levels.

Ideally, organizations of people who use drugs should lead any documentation efforts. Where this is not possible or where doing so would endanger them, it may be appropriate for local or international human-rights organizations—or international organizations of people who use drugs, if they are more protected—to assist.

No single approach to documenting human-rights violations will suit all situations. In some cases, accounts of a few extreme violations may be sufficient to sound the alarm. In others, it may be necessary to demonstrate many incidents. Different objectives may dictate different levels of human-rights analysis. Box 2.8 summarizes preparatory steps for organizations of people who use drugs seeking to record abuses.

Box 2.8

Tips and strategies for documenting human-rights violations

- ✓ **Clarify the objectives of the documentation:** is it meant to be a detailed record of many kinds of violations or to highlight a few key problems? What will be done with the documentation, and what will be needed to enable it to be used most effectively?
- ✓ **Identify the key issues or violations that you want to document:** make a preliminary list of violations known to the community and highlight the most important topics for documentation and advocacy.
- ✓ **Take account of what is known already:** based on the preliminary list, prepare a list of activists or groups knowledgeable about these violations and the actions they may have already taken, and subgroups of the population of people who use drugs who are likely to have encountered these violations.
- ✓ **Think about the information you need to collect:** compile a preliminary list of information that it will be necessary to collect (see Box 2.9). This may include medical records, photographs, videos, oral testimonies or written reports.
- ✓ **Identify all potential sources of information:** people, documents and organizations; where these are difficult to reach, consider alternate ways of getting information.
- ✓ **Develop a method based on what is needed:** the number of persons who use drugs to be interviewed, the number and identity of other experts, alleged perpetrators of violations and others, the degree of detail needed, the level of analysis of existing evidence etc.
- ✓ **Get informed consent:** it is important to have a mechanism for obtaining informed consent of those to be interviewed. Train interviewers to minimize re-traumatization of interviewees.
- ✓ **Develop resources to undertake an ethical and good-practice approach:** ensure also that the financial and human resources, and equipment (e.g. secure file storage) necessary for the investigation are in place.

Source: Kaplan K. [Human rights documentation and advocacy: a field guide for organizations of people who use drugs](#). New York (NY): Open Society Institute; 2009.

Box 2.9

The “6 W” guide for documenting human-rights violations

WHAT – What violation occurred? What was the accusation made, the law cited or the weapon used?

WHERE – The street, building or facility, and the address

WHEN – The time, day, date and year of the incident

WHO – Who was the direct victim? Who were the perpetrators? Are there witnesses or other people with direct knowledge of the violation (e.g. medical staff, police, outreach workers)?

WHY – Gather assessments or documentation from those most closely involved as to the circumstances, motivations, actions or words that led up to the violation.

HOW – How did the violation occur, and how did the victim’s status as a person who uses drugs contribute to the violation?

Adapted from: [Know your rights, use your laws: handbook for legal empowerment of people who live with or are at risk of HIV, their close ones, and service providers](#). New York (NY): United Nations Development Programme; 2014 and Kaplan K. [Human rights documentation and advocacy: a field guide for organizations of people who use drugs](#). New York (NY): Open Society Institute; 2009.

2.3.3 Addressing violence and other barriers by law-enforcement officers

People suspected of using drugs may be subjected to forced drug testing, searches and the destruction or confiscation of harm reduction equipment (sterile needles and syringes etc.) by police or other law-enforcement agents. They may also suffer beatings, torture or other cruel, inhuman or degrading practices during interrogation or detention, sometimes leading to death.

Box 2.10

Documenting punitive practices

Many organizations of people who use drugs and those that provide services to them have either documented police violence or harassment on an ad-hoc basis, or made it a systematic practice to monitor police stopping individuals near service points. Documenting punitive practices allows for advocacy either on an individual basis (addressing problems with a single police officer) or when addressing system-wide issues.

Documenting issues on an ad-hoc basis can include asking for police officers’ names and badge numbers to see whether harassment is an issue of one particular police officer. For systematic documentation, communities of people who use drugs share information regularly with needle and syringe distribution points so that these issues can be resolved on a district- or citywide basis. Other approaches include mapping locations where police harassment is occurring and sharing information on harassment instantly via text messages.

Some countries or agencies that conduct regular surveillance of HIV and HCV prevalence among key populations have added questions about police harassment and violence to yearly epidemiological assessment questionnaires. Advocating for such measures could be beneficial to countries, as it allows interested parties to monitor and track progress towards reducing police violence and human-rights violations.

Experiences from various parts of the world show that police attitudes and practices can change to be more respectful of human rights (Box 2.12). An important development has been the establishment of international groups such as the Law Enforcement and HIV Network (LEAHN), an organization of active and retired police officers and other former criminal-justice system workers who believe that the police have an important role to play in supporting the access of people who use drugs to harm reduction services. These groups are important resources for educating other police officers and the general public.

Box 2.11

**Excerpt from the LEAHN Statement of Support
for Harm Reduction Policing**

1. Historically, law-enforcement agencies have always played an essential role in the protection and maintenance of public health. Currently, preventing the spread of HIV is a major public-health challenge in which law enforcement plays a crucial role. As part of the response, harm reduction policies and practices are pragmatic, comprehensive, evidence-based approaches which have proven successful in reducing the spread of HIV throughout the world.
2. The prevention and reduction of crime and enhanced community safety are important goals and benefits of harm reduction programmes. Even where behaviours are unlawful, law-enforcement agencies can have a significant impact in creating an environment enabling key populations to protect both themselves and the community from harm, including HIV.
3. Law-enforcement agencies, as key partners in implementation of these programmes, are in a position to facilitate access to HIV prevention and treatment services. Law-enforcement agencies (particularly the police and prison services) can make a significant contribution to improving public health by actively participating in and supporting these programmes.
4. Law-enforcement and health sectors should work in partnership to develop and support legislation, policy and practice that facilitate the common goals of HIV prevention through enhancing community safety and crime reduction. Directly and through more appropriate allocation of law-enforcement and health resources they enhance the ability of law-enforcement agencies to achieve their goals of crime prevention, crime reduction and community safety.

Source: [LEAHN statement of support for harm reduction policing](#)

Website: www.leahn.org

At the local level, finding police champions and educating officers about HIV and harm reduction can have significant benefits. Police officers might be familiar with and sympathetic to such issues as drug use or HIV in their local community, but might need guidance in order to participate effectively in prevention programming. Organizing dialogues between civil-society organizations and law-enforcement officers helps increase mutual understanding of needs. Since police forces are hierarchical, it is often necessary for senior officers to provide leadership for such change to happen.

It is important that training and sensitization take place on a regular basis. The inclusion of training on harm reduction or HIV and key populations within the curriculum of a police academy allows for a large number of police to be trained in a sustainable manner. It should be presented in a way to appeal to the interests of the police, e.g. as a more rational use of their resources (pursuing major drug traffickers rather than people who have committed minor, nonviolent drug-related offences), and protecting themselves from needle-stick injuries. Organizations of people who use drugs can play crucial roles as advocates and trainers with the police (Box 2.12).

Box 2.12

Case example: Changing police attitudes and practices

In 2013–2014, UNODC conducted joint sensitization workshops for law-enforcement authorities and civil-society organizations in 18 countries. For two days, 40 participants, half from civil-society organizations and half from the police, were trained on harm reduction and on how to advocate with the police. In each city where the workshop was conducted, all participants agreed that they learned a lot from each other; it was the first time they had a place for joint dialogue. One result was that in 2016, CSOs and police developed joint plans of action in Armenia, Kazakhstan, Moldova and Ukraine.

UNODC has also developed a *Training manual for law enforcement officials on HIV service provision for people who inject drugs*, to be used in police academies or for in-service training, and a *Practical guide for civil society HIV service providers among people who use drugs: improving cooperation and interaction with law enforcement officials*.

The 2014 Open Society Foundations (OSF) publication *To protect and serve* highlights examples of improved attitudes of the police towards people who use drugs:

- **In Kolkata, India**, the deputy commissioner of police was persuaded of the wastefulness of pursuing people committing petty drug crimes, and worked with community groups to set up drop-in centres⁶ where people could get support and nonjudgemental health services. The success of those efforts depended on training a wary police force of the value of these services. The effort eventually helped transform police attitudes, enabled thousands of people who use drugs to get social services, and helped the drug police to target their resources more effectively against major criminals.
- **In Kyrgyzstan**, a high-ranking drug enforcement police officer saw the devastating impact of HIV in the country and became aware of the importance of harm reduction. With his

⁶ A drop-in centre is a place where people who inject drugs may gather to relax, meet other community members, and hold social events, meetings or training. See Chapter 4, Section 4.6, for details.

support, and working with human-rights and HIV prevention organizations as well as communities of people who use drugs, national guidelines on police involvement in the national HIV strategy were revised. Police were ordered not to interfere with harm reduction services, but attitudes did not change until countrywide training involving health workers and people who use drugs enabled rank and file officers to understand that they had an important role to play in ensuring access to life-saving services, and that people who use drugs were worth saving. The police academy has since developed an HIV curriculum and instituted regular training on harm reduction, and increasing numbers of police officers see ensuring access to HIV services as part of their job.

- In Baltimore, **USA**, where police officers were noted to approach individuals near needle distribution sites, the Police Department's Office of Occupational Health and Safety and the city's Health Department, which operated NSPs, offered training on HIV and harm reduction basics and described the benefits of harm reduction in terms of limiting police exposure to needles during searches. Police officers' fears of needle-stick injuries were addressed and prevention strategies were discussed. People who use drugs provided personal perspectives on their experience with the police. In addressing police concerns, the training took on a protective angle, explaining how harm reduction programming benefits all, including the police.

2.3.4 Forced or compulsory treatment

In many countries people who use drugs are sent by the courts to mandatory drug-dependence treatment or coerced treatment, either in the community as an alternative to incarceration, or in addition to incarceration. Drug-dependence treatment is a health service with the same ethical standards as any other. No treatment should be initiated without the informed consent of the client. The person who uses drugs must have the choice to accept or refuse this alternative.

In some countries, people charged with drug offenses—including minor, nonviolent offenses, and in many cases simply consumption and without a conviction—may be detained against their will in facilities that claim to provide treatment or rehabilitation and offer no freedom to leave the treatment facility. There they are often subjected to physical abuse, deprivation and forced, unpaid labour. A 2012 joint statement by 12 UN entities condemned these practices and called for states to “close [these centres] without delay and to release the individuals detained,” and to replace compulsory detention with voluntary community-based care for those who need it.⁷

7 **Joint statement: compulsory drug detention and rehabilitation centres.** International Labour Organisation; Office of the High Commissioner for Human Rights; United Nations Development Programme; United Nations Educational, Scientific and Cultural Organisation; United Nations Population Fund; United Nations High Commissioner for Refugees; United Nations Children's Fund; United Nations Office on Drugs and Crime; United Nations Entity for Gender Equality and the Empowerment of Women; World Food Programme; World Health Organisation; and Joint United Nations Programme on HIV/AIDS; 2012.

Box 2.13

Strategies to advocate for the closure of detention centres with compulsory or coercive treatment

Documenting abuses can be difficult or impossible where governments restrict access to these facilities and where “patients” or even former patients may fear to tell their stories. International human-rights organizations may be able to help, as in the case of Human Rights Watch’s revelation of abuses in compulsory drug detention centres in Cambodia, China, Laos and Viet Nam, and similar reporting on Thailand by the Canadian HIV/AIDS Legal Network. Human-rights organizations can help local civil-society organizations to make appeals to human-rights bodies, as Human Rights Watch has done in the Universal Periodic Review process of the UN Human Rights Council, based on the results of its investigations of these centres. Backed up by the clear UN position on this subject, UN staff should also be called upon to assist in advocacy to close these institutions.

2.3.5 Access to health services in detention

Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation.

Principle 9 of the [Basic principles for the treatment of prisoners](#), UN General Assembly

According to Harm Reduction International, in 2015 only eight countries offered NSP in prisons, and only 52 offered OST for people who were incarcerated. Treatment for HIV and tuberculosis is more widely accessible in prisons, but is still complicated by the competing priorities of health and prison authorities. In many countries, the provision of harm reduction and drug-dependence treatment services in detention settings is limited by legal or financial restrictions, or by official denial of the real situation in prisons. Resolving these legal barriers requires significant advocacy efforts and political will.

The UN [Rules for the treatment of women prisoners and non-custodial measures for women offenders](#) (the Bangkok Rules, 2013) and the UN [Standard minimum rules for the treatment of prisoners](#) (the Nelson Mandela Rules, 2015) provide clear guidance on the need to provide services in prisons equivalent to those available in the wider community, and to provide drug-dependence and HIV treatment and ensure their continuity.

Denying access to OST during interrogation, detention or in health-care settings may occur because systems have not been established to provide OST; to elicit a confession; from a misinformed desire to “treat” or “cure” drug use (despite the lack of any evidence for the basis or efficacy of this approach); or simply to punish. The UN Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment has stated that “denial of medical treatment and/or absence of access to medical care [including OST] in custodial situations may constitute cruel,

inhuman or degrading treatment or punishment and is therefore prohibited under international human rights law.”⁸

Box 2.14

Case example: Advocacy for prison needle and syringe programmes in Australia

In 2011, the Australian NGO Anex investigated the legislative and regulatory considerations underlying the introduction of prison NSPs in the state of Victoria. Anex found that legislation relating to workplace health and safety and the provision of reasonable medical treatment and care to prisoners establishes the duty of care underlying the provision of such programmes. This duty of care is reinforced by the state’s Charter of Human Rights and Responsibilities Act 2006. To establish NSP in prisons, compliance with the state’s Corrections Regulations 2009 is required and consent must be obtained from the prison governor.

Source: *A handbook for starting and managing needle and syringe programmes in prisons and other closed settings*. Vienna: United Nations Office on Drugs and Crime; 2014.

www.anex.org.au

The following points can be used to advocate for health care and harm reduction services in prisons:

- **Show the need:** conduct a review of the epidemiologic situation in prisons in the country, including data on infectious disease incidence, injection and risk behaviours inside prisons.
- **Show the obligations under international and national law** dealing with human rights, health or the standards of prison facilities and legal obligations. People in prisons are entitled to health care equivalent to that received by the non-incarcerated population.
- **Show the scientific evidence on the effectiveness of interventions in prisons**, e.g. the World Health Organization (WHO), UNODC and UNAIDS publication *Interventions to address HIV in prisons: drug dependence treatments*.
- **Show international guidance**, e.g. the UNODC, International Labour Organization and WHO publication *HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions* (2013).
- **Show the benefits for prison staff**, i.e. workplace safety—where needles and syringes are allowed, prisoners will either exchange them, dispose of them instantly or do not feel the need to hide them where staff might be injured during searches. Providing access to OST to people in need in prisons reduces drug trafficking and facilitates prison management.
- **Show the benefits for the entire population:** prison health is public health—where needles and syringes are allowed, prisoners do not share injection equipment, reducing the risk of transmitting HIV and HCV among prisoners and their partners, in prisons or after release.

⁸ Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development. Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Manfred Nowak. United Nations General Assembly A/HRC/10/44, para. 71. New York (NY): United Nations; 2009.

- **Show the benefits of involving prisoners in support services:** people who use drugs can be involved in prison NSPs, assisting with provision of information and education, HIV testing services, overdose management, and helping prison and medical staff make programming more effective.

For an example of advocacy material, see: Harm Reduction International's [Advocating for needle and syringe exchange programmes in prisons. Evidence and advocacy briefings series](#).

2.3.6 Advocating for gender-responsive harm reduction services

Women who inject drugs often experience greater stigma and discrimination than men who inject, and this is often heightened by gender-based violence. They face a range of gender-specific barriers to accessing HIV-related services, and in many contexts they remain a particularly hard-to-reach population, even where harm reduction programmes are in place.

Other laws and policies that affect women and their access to HIV services include those where indicating drug use is criterion for loss of child custody, for forced or coerced sterilization or abortion.⁹ However, research indicates that with access to adequate medical and social support, women who inject drugs can have healthy babies and provide their children with appropriate care and a loving and supportive developmental environment. Organizing women who use drugs—particularly through community-led women's groups and networks—coupled with targeted efforts to stop violent practices against them, can contribute to improvements in drug policy and access to reproductive health services.

The UNODC policy brief [Women who inject drugs and HIV: addressing specific needs](#) (2014) lists interventions that respond to the needs of women who inject drugs:

- sexual and reproductive health services, including for STIs and prevention of mother-to-child transmission of HIV
- maternal and child health services
- gender-specific peer education and support
- services related to gender-based violence
- services tailored for sex workers who inject drugs
- provision of male and female condoms
- parenting support
- child care
- couples counselling (aimed at ensuring that the responsibility for reducing HIV and health risks is equally shared between partners)
- information, education and communication that is specifically relevant to women who inject drugs (including safer injecting and safer-sex techniques)
- legal aid that is accessible and relevant to the needs of women who inject drugs

⁹ Coerced abortions include the overt use of physical force or emotional or psychological pressure to make a woman have an abortion against her will, as well as cases where a woman is manipulated by misinformation (for example about the effects of using drugs during pregnancy) or financial incentive into consenting to an abortion that she might not otherwise have freely chosen to undergo.

- provision of psychosocial and ancillary services and commodities
- income-generation interventions for women who inject drugs.

For more information, see also the UNODC *Addressing the specific needs of women who inject drugs: practical guide for service-providers on gender-responsive HIV services* (2016).

Box 2.15

Case example: The International Network of Women Who Use Drugs (INWUD)

INWUD is a subsidiary group of INPUD (the International Network of People Who Use Drugs). The organization provides a women-only online safe space (via a listserve) where ideas, challenges and support can be shared. INWUD promotes equity for women on all INPUD boards and working groups, and reviews and has input into all INPUD documents to ensure they are sensitive to women prior to their publication.

INWUD engages and promotes women who use drugs as equal partners and contributors in all aspects of drugs theory and practice, including policy, legal reform and harm reduction development. The group actively seeks to collaborate with relevant UN and other international groups and bodies to give greater voice to issues affecting women who use drugs. INWUD prepared a position statement for the 2016 UN General Assembly Special Session on the World Drug Problem.

In 2014 INWUD worked in collaboration with the National Advocates for Pregnant Women in the USA to make a submission to the UN Human Rights Council on the rights of pregnant women who use drugs; and in 2015 it partnered with the International Community of Women Living with HIV (ICW) to produce a joint position statement on women who use drugs and HIV. These are examples of a women drug users' network working with more mainstream women's networks to improve the human rights of women who use drugs and reduce stigma and discrimination.

2.4 Addressing stigma and discrimination

The extreme level of stigma routinely experienced by people who inject drugs is a form of structural violence. The language, policies and practices of legal, health and educational institutions and the media often create, reinforce and perpetuate this stigma. This makes it more difficult to reform harsh drug laws or properly resource HIV and HCV prevention, diagnosis, treatment and care programmes for people who use drugs. Stigma can lead to toleration of human-rights violations against people who use drugs and is also used to legitimize discriminatory practices.

Examples of legal, social and institutional discrimination include restrictions on funding of health services such as injection equipment for distribution through NSPs; legal prohibitions on OST; impeded access to harm reduction services through zoning rules or the opposition of the wider community to having services in their neighbourhood; and age restrictions or requirements for parental consent for treatment, which limit young people's access to services.

Box 2.16

Forms of stigma related to people who use drugs

Stigma from individuals: the negative views and stereotypes held by individual members of society towards people who use drugs. These may be based on personal observations and direct experiences, or on media reporting, government laws and policies.

Stigma from services/programmes: policies and practices that create barriers to service access, e.g. judgemental attitudes of service-providers, lack of confidentiality or privacy for the client, lack of informed consent for treatment, or coercive, compulsory or abusive treatment.

Systemic, structural or institutional stigma: punitive and harsh drug-control laws and coercive and corrupt law-enforcement practices, including violence and extortion; and policies that officially restrict or prohibit access to public services for people who inject or otherwise use drugs.

Self-stigma: the internalization of stigmatizing views and attitudes by people who use drugs.

Stigma by association: stigma directed against family and friends of people who use drugs, or against those who express empathy or support for people who use drugs, or who support more progressive drug laws, or against providers of harm reduction services or researchers.

Adapted from: [Understanding drug-related stigma: tools for better practice and social change](#). New York (NY): Harm Reduction Coalition.

2.4.1 Local-level programming to reduce stigma and discrimination

Use participatory methods. People who use drugs should be invited to engage in processes to identify their problems, analyse causes, identify priorities and develop solutions. Such methods strengthen programme relevance, build life and relationship skills and help ensure the long-term success of programmes.

Understand local patterns of stigma and discrimination against people who use drugs and the relationship between these and vulnerability to HIV and HCV. Use this understanding as the basis for designing programmes.

Use an integrated approach in designing interventions. A greater impact on stigmatization and discrimination against people who use drugs can be achieved via broad-based programmes that provide information and holistic health services, work with the legal and justice sectors and are community-based.

Build capacity of programme staff to understand and address the links between stigma and discrimination against people who use drugs and HIV. Programme staff should be able to respond sensitively to people who use drugs who experience discrimination or violence, without further stigmatizing or blaming them.

Recognize that programmes may have unintended harmful impacts for people who use drugs, such as retaliatory or “backlash” violence. Prepare for this possibility and monitor programmes for such unintended consequences.

Evaluate programmes to identify strategies that reduce risk factors and levels of discrimination faced by people who use drugs, in order to build the evidence base and ensure that resources are directed to the most beneficial strategies. Evaluation should always take place with the participation of people who use drugs themselves.

Box 2.17

Checklist for a code of good practice to combat stigma and discrimination within a service or organization

This checklist can help an organization providing services to people who use drugs to develop or evaluate a code of good practice to eliminate stigma and discrimination. Completing the checklist is best done as a team exercise, which can be repeated on a regular basis (at least once a year). The questions and statements are suggestions and should be tailored to the type, size and scope of the organization. They can be assessed against a scoring framework such as: **Y**—yes, we currently do this well, **NI**— we currently do some work in this area but it needs improvement, **NC**—not currently undertaken/we currently do not work in this area, **NA**—not applicable to our work/organization. An action plan should be developed to address any areas that are identified as **NI** or **NC**.

Language: Do written policies and practices use language that is nonjudgemental, neutral and empowering (e.g. “person who injects drugs” or “drug-dependent person” rather than “drug addict”, “drug abuser” etc.)?

Confidentiality and privacy: Are all services provided in a manner that is confidential and protects people's privacy? Does the organization ensure people are not asked about their drug use, HIV or HCV status in front of other clients? Can female and young service-users access programmes (such as OST) without being required to have a “guardian” (partner or family member) with them?

Assumptions: Are policies and practices free of assumptions about people accessing services, e.g. assuming that drug users who present for treatment for illness or relief of pain are simply “seeking drugs”; treating people known to use drugs differently from other clients; or refusing services because they are viewed as “trouble” or “difficult”?

Data protection: Are all personal records and data about service-users managed through a system that is safe and confidential? What information are people required to provide, and could it make them vulnerable to police action, child protection intervention or violence in the community? Is it absolutely necessary to gather all information that is recorded? What local laws assist or obstruct the protection of data?

Informed consent: Is full and informed consent gained before any medical tests or procedures are undertaken? How do you know that consent has really been given freely?

Voluntary: Are all services and programmes provided on a voluntary basis, i.e. clients can enter and leave when they choose and are not forced to enter or remain, either by the organization, the police, the courts or family members?

Nonpunitive: Can service-users be removed from the service or denied access for certain reasons? Are these reasons fair and do they put the person's health first and include a process of appeal? Have service-users been fully involved in the drafting of these rules, and are new service-users informed of these rules upon arrival?

Safety: Are there policies and procedures to ensure that every service-user feels safe accessing programmes?

Evidence-based: Are all services and programmes based on the best available and scientifically sound evidence of good practice?

Meaningful involvement: Are service-users involved in the planning, development and implementation of services? Does the organization work with and involve a local or national organization of people who use drugs? Is there an accessible way for service-users to provide feedback and tell you what services they want or need?

Complaint mechanism: Is there a complaints mechanism that people are comfortable accessing and are able to use easily? How is this publicized?

Staff training and support: Are adequate training and support provided to all staff working with people who use drugs for the roles they undertake?

Employment of people who use drugs: Are people who use drugs also employed as full staff members, and are they given the same training and remuneration as staff who do not use drugs?

2.4.2 Changing attitudes towards people who use drugs

Influencing the media

Many people gain their information and opinions about injecting drug use from the mainstream media. Several strategies have been used to challenge stigmatizing and discriminatory media portrayals of people who use drugs (Box 2.18).

Box 2.18

Case example: Strategies for challenging stigmatizing and discriminatory attitudes in the media

- Since 2011, the Latin America regional conferences on drug policy, convened by a consortium of NGOs led by Intercambios in Argentina, have offered awards for the best Latin American journalism on drugs and drug policy. Many journalists have entered the competition, and Intercambios believes that the competition has improved news coverage.
- The West African Commission on Drugs conducted a workshop for journalists in that region to encourage better coverage of drug policy issues. Participating journalists examined the results of the war on drugs and the impact of media discrimination against people who use drugs.

Communities of people who use drugs have also organized collective campaigns to address discrimination in the media (Box 2.19).

Box 2.19

Case example: Challenging discriminatory views in the press in Ukraine

Despite national efforts to establish well-run OST and support programmes, communities of people who inject drugs in Ukraine have been heavily stigmatized. In 2006–2008, as Ukraine began scaling up methadone and buprenorphine programming, an anti-drug national billboard campaign was launched by a local nonprofit agency using stigmatizing language about people who use drugs. In response, the All-Ukrainian Charitable Foundation “Drop-In Centre” (an NGO of people who use drugs) and the Association of Substitution Therapy Advocates of Ukraine (ASTAU) launched a campaign to highlight the opportunities presented to people who inject drugs by OST. Billboards in five cities ran the message: “Return ticket: what can help an individual who uses drugs to return to work/family/society? ASK!” The Ukrainian acronym for OST is ZPT, which is similar to the Ukrainian verb “ask”—*zapitay*. Viewers were encouraged to visit the campaign’s website, zapitay.in.ua, which discusses the benefits of OST. In addition to the billboards, press releases and press conferences conducted by people who use drugs and OST clients and their parents contributed to an improved societal understanding of people who use drugs and their communities.

Creating a voice for people who use drugs

Some organizations of people who use drugs have created magazines, newsletters, Internet blogs, videos and other online resources to counter stigmatizing and discriminatory media reporting. These provide an alternative, humanizing perspective about people who use drugs, as well as essential, nonjudgmental peer education and harm reduction information. Peer-based publications, online resources and advocacy statements have been produced even in environments where drug use is criminalized and people who use drugs are vulnerable to arrest.

Box 2.20

Community-led publications, resources and advocacy tools

For ideas on how to create or further develop a “drug users’ voice” in your local context, refer to these drug user-led publications, resources and advocacy tools from a range of settings:

We are drug users: voices from the international movement of people who use drugs. (YouTube video; 2014.)

INPUD consensus statement on drug use under prohibition: human rights, health, and the law. London: International Network of People Who Use Drugs; 2015.

Paper planes (Canberra: Australian Injecting & Illicit Drug Users League; 2014) is a book that uses a simple narrative to encourage people to examine their own prejudice towards women who use drugs and to challenge stigma and discrimination.

Advocating with stakeholders

Another strategy for influencing the public and the media is to mobilize statements by celebrities or other high-profile persons whose stature draws media attention. The Global Commission on Drug Policy, a group convened in 2010 including former heads of state, activists and intellectuals, has drawn considerable attention to drug policy issues. The 2014 report of the West Africa Commission on Drugs received wide coverage in the media and has helped to open debates on the negative impact of discrimination and human-rights violations against people who inject drugs across Africa. Efforts to advocate with government and NGOs may also be successful (Box 2.21).

Box 2.21

Case example: Advocacy to increase acceptance of Roma people who use drugs

In 2012 the Romanian NGO Carusel developed an advocacy project to sensitize Romania's National Agency for Roma (NAR) and other major Roma NGOs to the drug use situation in the community, especially regarding the vulnerability, stigma and discrimination faced by Roma drug users. In order to build political will and commitment on these issues, Carusel recognized that wider community acceptance was the first step.

Carusel's advocacy strategy includes dissemination of key human-rights and public-health messages, sensitization and capacity-building trainings, and field visits for data collection, outreach to community leaders and supervision of activities. People who use drugs are themselves involved in all project activities. A scholarship programme supports young people to attend the Roma Harm Reduction Summer School to develop outreach and harm reduction advocacy skills.

As a result of this work, NAR and other Roma NGOs are becoming more understanding of drug use in the Roma community, and there is greater acceptance of the users themselves. Roma NGOs provide financial assistance for Carusel to purchase harm reduction supplies and to provide technical expertise for reporting cases of human-rights violations against all drug users. The needs of Roma drug users—including culturally appropriate harm reduction activities—are now addressed in the strategy and action plans of the National Anti-drug Agency.

www.carusel.org

2.5 Monitoring programmes

Monitoring and evaluation of stigma, discrimination and violence prevention and response efforts is important because:

- These strategies are a key component of HIV prevention and treatment programming globally, informed by the evidence that HIV can only be defeated by ensuring enabling environments for key populations.
- Data on the experience of stigma, discrimination and violence by people who use drugs can provide a basis for planning and designing appropriate strategies.

- Routine monitoring allows programmes to identify whether there are any unintended consequences of programmes and interventions (e.g. “backlash”).
- Evidence of the stigma, discrimination and violence faced by people who use drugs is a powerful tool for advocacy to change laws and policies and create an enabling environment for promoting the rights of people who use drugs.

The 2015 WHO *Tool to set and monitor targets for HIV prevention diagnosis, treatment and care for key populations* provides indicators that can apply to people who use drugs in the context of human rights and enabling environments. Suggested indicators are given below:

To monitor stigma and discrimination:

- percentage of drug users reporting stigma and discrimination
- percentage of service-providers surveyed responding that they “agree” or “strongly agree” to a collection of discriminatory statements.

To assess work in the area of providing an enabling environment:

- involvement of people who use drugs in policy and strategy formulation
- number of services providing legal support to drug users
- support services for people who use drugs who experience violence
- sensitization trainings on people who use drugs for health-care providers/law-enforcement officers.

The development of indicators should be done in consultation with, or by, communities of people who use drugs.

2.6 Further resources

1. Policy brief – HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions. Vienna: United Nations Office on Drugs and Crime, International Labour Organization, World Health Organization; 2013.
http://www.who.int/hiv/pub/prisons/interventions_package/en
2. UNODC and the promotion and protection of human rights: a position paper. Vienna: United Nations Office on Drugs and Crime; 2012.
http://www.unodc.org/documents/justice-and-prison-reform/UNODC_Human_rights_position_paper_2012.pdf
3. From coercion to cohesion: treating drug dependence through health care, not punishment. Vienna: United Nations Office on Drugs and Crime; 2010.
http://www.unodc.org/docs/treatment/Coercion/From_coercion_to_cohesion.pdf
4. Training manual for law enforcement officials on HIV service provision for people who inject drugs. Vienna: United Nations Office on Drugs and Crime; 2014.
http://www.unodc.org/documents/hiv-aids/LE_MANUAL_o2.10.14.pdf
5. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations–2016 update. Geneva: World Health Organization; 2014.
<http://www.who.int/hiv/pub/guidelines/keypopulations-2016/en>

6. WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users–2012 revision. Geneva: World Health Organization; 2013.
<http://www.who.int/hiv/pub/idu/targetsetting/en>
7. “Nothing about us without us”: greater, meaningful involvement of people who use illegal drugs: a public health, ethical, and human rights imperative. Toronto (ON): Canadian HIV/AIDS Legal Network, International HIV/AIDS Alliance, Open Society Institute; 2008.
<https://www.opensocietyfoundations.org/reports/nothing-about-us-without-us>
8. Legislating for health and human rights: model law on drug use and HIV/AIDS—Module 7: stigma and discrimination. Toronto (ON): Canadian HIV/AIDS Legal Network; 2006.
<http://www.aidslaw.ca/site/legislating-for-health-and-human-rights-model-law-on-drug-use-and-hiv-aids-module-7-stigma-and-discrimination>
9. Human rights documentation and advocacy: a guide for organizations of people who use drugs. New York (NY): Open Society Institute; 2009.
http://www.opensocietyfoundations.org/sites/default/files/hrdoc_20090218.pdf
10. Know it, prove it, change it: a rights curriculum for grassroots groups. Bangkok: Thai AIDS Treatment Action Group, Dongjen Center for Human Rights Education and Action, Asia Catalyst; 2010.
<http://asiacatalyst.org/resources/cbo-resources>
11. Handbook of basic principles and promising practices on alternatives to imprisonment. Vienna: United Nations Office on Drugs and Crime; 2007.
http://www.unodc.org/pdf/criminal_justice/o7-80478_ebook.pdf
12. Toolkit: scaling up HIV-related legal services. Rome: International Development Law Organization (IDLO) and United Nations Joint Programme on HIV/AIDS; 2009.
http://data.unaids.org/pub/Manual/2010/20100308revisedhivrelatedlegalservicetoolkitwebversion_en.pdf
13. Practical guide for civil-society HIV providers among people who use drugs: improving cooperation and interaction with law-enforcement officials. Vienna: United Nations Office on Drugs and Crime, International Network of People Who Use Drugs, Law Enforcement and HIV Network.
http://www.unodc.org/documents/hiv-aids/2016/Practical_Guide_for_Civil_Society_HIV_Service_Providers.pdf
14. Addressing the specific needs of women who inject drugs: practical guide for service-providers on gender-responsive HIV services. Vienna: United Nations Office on Drugs and Crime; 2016.
http://www.unodc.org/documents/hiv-aids/2016/Addressing_the_specific_needs_of_women_who_inject_drugs_Practical_guide_for_service_providers_on_gender-responsive_HIV_services.pdf



3

Services



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What's in this chapter?

This chapter discusses how to implement the recommended **package of health services** for people who inject drugs. The services covered in this chapter are:

- Needle and syringe programmes (Section 3.2)
- Opioid substitution therapy and other evidence-based drug-dependence programmes (Section 3.3)
- HIV testing services (Section 3.4)
- Antiretroviral therapy (Section 3.5)
- Sexually transmitted infection services (Section 3.6)
- Sexual and reproductive health (Section 3.7)
- Condom and lubricant programmes (Section 3.8)
- Information, education and communication (Section 3.9)
- Prevention, vaccination, diagnosis and treatment of viral hepatitis (Section 3.10)
- Prevention, detection and treatment of tuberculosis (Section 3.11)
- Prevention and management of overdose (Section 3.12)
- Psychosocial services (Section 3.13).

The chapter also provides a list of **further resources** (Section 3.14).

3.1 Introduction

The World Health Organization (WHO), the United Nations Office on Drugs and Crime (UNODC) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) defined an evidence-based public-health response for people who inject drugs with a comprehensive package of nine interventions in a technical guide published in 2009 and revised in 2012.¹ This harm reduction package has since been expanded² to include the following interventions:

1. Needle and syringe programmes (NSPs)
2. Opioid substitution therapy (OST) and other evidence-based drug-dependence treatment
3. HIV testing services (HTS)
4. Antiretroviral therapy (ART) for people living with HIV
5. Prevention and treatment of sexually transmitted infections (STIs) (and sexual and reproductive health services)
6. Condom programmes for people who inject drugs and their sexual partners
7. Targeted information, education and communication (IEC)
8. Prevention, vaccination, diagnosis and treatment of viral hepatitis B and C
9. Prevention, diagnosis and treatment of tuberculosis (TB)
10. Community distribution of naloxone for prevention and treatment of opioid overdose.

In mapping communities of people who inject drugs before establishing services, data on the availability and quality of harm reduction services, current use of services, their acceptability and accessibility should also be collected. This information may be used to determine the need to make services available and develop a plan to improve existing services or establish new ones for people who inject drugs. For more information on mapping, see Chapter 5, Section 5.2.1.

3.2 Needle and syringe programmes

The provision of sterile injecting equipment through NSPs is highly effective in reducing transmission of HIV and hepatitis B and C. NSPs facilitate the use of sterile needles and syringes and reduce the number of injections with unsterile or used equipment. NSPs have proven to be effective and cost-effective and have not been shown to increase drug use³ or injecting. NSPs should not operate in isolation: a multidisciplinary approach is essential. NSPs also serve as an important point of entry for people who inject drugs to other health and social services, which they might otherwise be reluctant to use.

People who inject drugs play a crucial role in the design, delivery and implementation of NSPs. As peers they are able to attract people who would otherwise be reluctant to attend services. Furthermore, they are able to distribute needles and syringes to hard-to-reach groups. Staffing NSPs with peers is recommended.

Needle and syringe needs will differ according to the drug injected. People who inject cocaine may inject up to 20 times a day for a few days and then stop for one or two days. By contrast, people who inject heroin tend to do so one to three times a day.

1 *WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. 2012 revision.* Geneva: World Health Organization; 2013.

2 *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations—2016 update.* Geneva: World Health Organization; 2016.

3 Drug use refers to the nonmedically sanctioned use of psychoactive drugs, including drugs that are illegal, controlled, or prescription.

The best-practice characteristics of NSPs are that they:

- are low-threshold, easy to enrol in, harm reduction-oriented, and actively attract clients into services
- offer a range of commodities, all free of charge (see Box 3.1)
- engage community members⁴ in the selection and distribution of commodities
- do not impose the strict exchange of needles and syringes, i.e. that clients are required to bring in used equipment before receiving new injecting equipment; this model increases the risk of needle and syringe sharing and is not recommended
- do not restrict the number of needles and syringes provided and do not prevent secondary distribution
- offer a range of other support and care services by qualified staff, such as on-site medical care and information about health maintenance (e.g. vein care and abscess management)
- are accompanied by a safe disposal plan to prevent accidental hazards (including to people from the wider community) from discarded used injecting equipment
- offer overdose management, both by ensuring all staff are trained in overdose revival techniques and by providing naloxone to people who inject opioids and their families and members of the wider community (see Section 3.12)
- use all available opportunities to discuss individual risks with people who inject drugs, opportunities to reduce risk and available risk reduction services
- are integrated with other services where possible and offer referrals to drug treatment, legal aid, family and housing advice and safer injection sites, where available, as well as testing for HIV, TB and viral hepatitis (see also Chapter 4, Section 4.2.2)
- continually assess results to understand the changing needs of their clients.

The WHO *Guide to starting and managing needle and syringe programmes* (2007) describes in detail how to begin and manage an NSP.

⁴ In most contexts in this tool, “community” refers to populations of people who inject drugs, rather than the broader geographic, social or cultural groupings of which they may be a part. People may move into or out of injecting drug use at various times in their lives but may maintain community connectedness. Thus, “community members” are people who inject drugs or people with community connectedness, “outreach to the community” means outreach to people who inject drugs, and “community-led interventions” are interventions led by people who inject drugs or people with community connectedness. For a closer definition, see Chapter 1, Box 1.1.

Box 3.1

What commodities should an NSP provide?

At its most basic, an NSP provides sterile needles and syringes to people who inject drugs. The types (gauge and volume) should be those preferred by local people who inject drugs. Whenever feasible, possible and acceptable to the injecting community, NSPs should also provide low-dead-space syringes (LDSS—see Box 3.3). It is not recommended to use self-retracting syringes for NSPs. NSPs should also provide a range of related commodities that are also essential for hepatitis C (HCV) prevention:

- condoms and lubricant
- filters
- sterile water
- alcohol swabs
- cotton swabs
- spoons
- puncture-proof containers
- acidifiers
- tourniquets.

Programmes should also distribute IEC material and the addresses of relevant health and social services, and should have naloxone available for overdose treatment.

3.2.1 Modes of service delivery

There are two basic modes of delivering NSP services: fixed sites and mobile services. Many of the most effective NSPs provide both.

A **fixed site** is a place where people who inject drugs can collect new injecting equipment, dispose of used needles or syringes, and possibly make use of other services. Examples of fixed sites include:

- **Drop-in centre:** Here people who inject drugs can access a range of harm reduction services alongside NSP (see Chapter 4, Section 4.6).
- **Needle and syringe programme centre:** Where a drop-in centre is not available, a distribution centre allows an NSP to begin or expand with limited cost and resources.
- **Pharmacies:** In many settings pharmacies are an important resource for NSPs and can link clients to broader harm reduction services (see Box 3.2).
- **Other secondary outlets** such as shops and cafes can be used as distribution points for NSP in areas with high rates of drug use.
- **Vending machines** are a practical solution for public or semi-public places where people inject drugs, such as underground passages or public toilets.
- **Drug treatment sites** should provide access to sterile needles through dedicated staff.

Box 3.2

Case example: Using pharmacies to expand an NSP in Ukraine

In Ukraine, the Alliance for Public Health (formerly the International HIV/AIDS Alliance) involved a number of pharmacies as secondary outlets for distributing injecting instruments, other prevention commodities and information to people who were reluctant to contact specialized harm reduction services. In certain parts of Ukraine the involvement of pharmacies allowed the programme to increase overall coverage by as much as 10% within a year of introduction. In 2015 there were 97 pharmacies involved in service delivery across Ukraine, reaching some 22,000 people who use drugs with NSP during the year.

Mobile services are provided from a van, bus, motorbike or other vehicle, or by individuals on foot. Usually a regular route with regular hours is followed, stopping to distribute commodities at several locations frequented by people who inject drugs.

- **Mobile clinics:** Mobile NSP can be expanded to include clinical services as well as medical investigation, including HTS and further referral to treatment programmes. Alternatively, existing mobile clinics can start dispensing needles and syringes.
- **Outreach/backpack:** Workers travel through streets or visit other settings to distribute sterile needles and syringes and other commodities, and collect used injecting equipment for safe disposal.
- **Secondary syringe distribution:** Using networks of people who inject drugs is effective for recruiting new clients into NSP, for example by providing an active client with a large quantity of syringes to distribute to their peers. It also enables people who wish to remain hidden or cannot come to the service, to get sterile injecting equipment.

Every NSP must establish a protocol for transporting and disposing of used injecting equipment. This equipment can be a serious hazard for staff and the general public, and the NSP should consider itself responsible for all steps in the disposal process, from the collection of used equipment from clients to its ultimate destruction, where possible in a medical-waste facility. It is important that NSPs take measures to make it simple for people to return or deposit used syringes. These may include installing safe collection boxes in hotspot areas. Not only is this vital for public health, i.e. to avoid accidental punctures, but it will also improve the acceptability of harm reduction by the wider community.

Although NSP clients should always be encouraged to return used injecting equipment to the NSP or mobile service, the return of used injecting equipment should not be a condition for provision of new equipment. Some NSP clients may not be able to carry used equipment safely, or there may be risk of police search and arrest. The primary aim of the NSP is to provide sterile equipment to reduce re-use of injecting equipment and to ensure its safe disposal. It is essential to minimize any barriers or pre-conditions for this distribution.

Box 3.3**Case example: Improving LDSS coverage in Viet Nam**

Low-dead-space syringes (LDSS) are designed to reduce the amount of blood remaining in the syringe after completely pushing down the syringe plunger. Studies have shown that this difference in dead space reduces the survival of HCV and HIV in blood remaining in syringes, leading to a reduction in the transmission of these viruses. WHO suggests that NSPs provide LDSS for distribution to people who inject drugs (*Guidance on prevention of viral hepatitis B and C among people who inject drugs* [2012]).

In Viet Nam, LDSS are preferred by the majority of people who inject drugs in Ho Chi Minh City and a few other localities, but they are not widely available in the central and northern areas of the country. Healthy Markets, an initiative of the US Agency for International Development and PATH, is working with local and international manufacturers to make LDSS more widely available, particularly in areas where there are increases in new HIV infections due to sharing. Part of this effort will involve bringing down the price of LDSS, which are currently four to five times the price of high-dead-space syringes. The initiative will also help local manufacturers secure ISO standards so that they are able to make LDSS available to the government and outside Viet Nam.

3.2.2 Providing NSP to people who are incarcerated

Models for distribution of needles and syringes in prison include installing vending machines, outreach to prisons by nongovernmental organization (NGO) workers or prison inmates, or distribution by prison medical staff. For more information, see the UNODC *Handbook for starting and managing needle and syringe programmes in prisons and other closed settings* (2014).

Box 3.4**Case example: Prison NSP and OST in Moldova**

NSPs have been operating in prisons in Moldova since 1999 through regulations that allow syringes into prison as medical equipment as part of the national HIV programme, and OST was introduced in 2005. The NSPs are run by peer volunteer inmates in collaboration with medical staff. The NSPs also serve as sites for condom distribution, IEC and overdose management. All volunteers have been trained in providing first aid, and naloxone is available at every NSP site. As a result of the programme, HIV and HCV prevalence among prisoners decreased by more than 50% over a period of five years.

3.3 Opioid substitution therapy and other evidence-based drug-dependence treatment

Treatment of drug dependence typically blends different treatment modalities, but approaches may be simply categorized as psychosocial or pharmacological. Pharmacological approaches can be further categorized as detoxification, relapse prevention and treatments to reduce drug craving and use. At present, no approved medications are available for the treatment of dependence on

cocaine, crack, or amphetamine-type substances (ATS). As a general principle, psychosocial interventions should be part of comprehensive treatment for drug dependence.

Opioid substitution therapy (OST) has been proven to be the most effective drug-dependence treatment for preventing HIV among people who inject and are dependent on opioids. OST is an effective, safe and cost-effective medical treatment that is also proven to reduce the frequency of injecting heroin or other opioids and the associated risks of overdose, infection and transmission of bloodborne viruses, as well as reducing criminal activity. In addition, OST is effective for encouraging adherence to ART for people who are HIV positive, and adherence to TB treatment.

Where OST is not available, or in cases of dependency on non-opioid drugs such as cocaine or ATS, the only treatment options are psychosocial interventions and withdrawal management (see Section 3.3.5). However, these are less effective in the prevention of HIV among people who inject drugs. For more information, see the WHO 2016 *mhGAP intervention guide for mental, neurological and substance use disorders in nonspecialized health settings—version 2.0* (2016) and the WHO Western Pacific Regional Office's *Technical briefs on amphetamine-type stimulants (ATS)*.

3.3.1 OST programme-level guidelines

To achieve optimal coverage and treatment outcomes, OST should be accessible to anybody in need of treatment who meets the criteria for inclusion, whether or not they inject, and be provided free of charge or be affordable or covered by public health insurance. OST can be delivered in primary health-care settings or in specialized outpatient clinics. An induction period where dosage is slowly increased, coupled with medical monitoring over a two-week period, is recommended. Research has shown that longer-term OST at higher dosages is more effective than shorter-term programmes aimed at detoxification, and treatment plans should take a long-term perspective. For more detailed clinical guidance, see the WHO *Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence* (2009).

Staff requirements and teamwork

Programmes should develop a clinical protocol based on national or WHO guidelines. While prescriptions must usually be written by a physician, OST may be dispensed by pharmacists or medical and nursing staff, or in community-based clinics, depending on national laws. Community-based outreach and support should also be provided (see Chapter 4).

Creating a welcoming environment

Treating clients with respect and dignity and making the clinic as pleasant and relaxing as possible will make the process of repeated clinic visits more tolerable for clients, and afford the staff safety. Putting up bars or screens to separate clients and service-providers inevitably creates mistrust. Similar attention must be paid to the external amenities of the clinic. Signage on the outside of the building should be discreet in order not to attract unwanted attention and to allow clients anonymity.

Box 3.5

OST as a holistic treatment

Offer help with social integration: Individual or group counselling and self-help groups can help OST clients develop communication and socialization skills. Peer support groups have also been an important emotional resource for people who inject drugs in many settings.

Work with peer advocates so that client feedback informs services: Local organizations led by people who inject drugs can help OST providers by providing information to people who inject drugs, OST clients, parents and relatives, as well as to doctors and the general public. They can also train local clients to become peer advocates for OST or to staff information hotlines.

Work with family and relatives for a supportive environment: To ensure the effectiveness of OST and the quality of clients' lives, programmes should offer psychological and social services to families and friends of programme participants (and especially to children, ensuring that they are kept with the parents and family wherever possible). However, it is essential that clients retain their right to confidentiality.

Advocate for OST and clients' rights: It is important to engage in advocacy for clients' rights to access high-quality and sustained OST, and expanded programmes. Advocacy by programme providers can be done alongside peer advocacy networks and family groups, who can also help mobilize national campaigns for access to treatment.

3.3.2 Providing treatment

Inclusion criteria

The criteria for entering OST differ widely between programmes and countries, and may include: minimum age, length of opioid dependence, physical and mental health, and personal motivation. OST is indicated for people who are opioid-dependent (non-injectors as well); who are able to give informed consent, and for whom there are no specific contraindications. Most successful programmes are low-threshold, i.e. easy to enrol in, harm-reduction oriented, offer a range of treatment options, and actively attract people who inject drugs into services.

Choice of treatment approach

WHO recommends OST primarily for longer-term maintenance therapy. Both methadone and buprenorphine are on the WHO List of Essential Medicines for the treatment of substance dependence. To cover different clients' needs, it is recommended to have both medications available for OST.

Some opioid users repeatedly fail to respond to methadone and buprenorphine. In a few countries, prescription morphine and/or supervised injectable diacetylmorphine (medical heroin) is available for difficult-to-treat clients. Treatment is delivered under direct medical supervision to ensure safety and prevent diversion. Research shows that this treatment can lead to improved health and well-being of this group, including improvements in social functioning.

Box 3.6

Key principles for OST

Retention in therapy: The use of illegal drugs while in OST should never be a reason for excluding a client from the programme. This could indicate the need for a clinical adjustment of the treatment. However, the medication dosage must never be adjusted as a reward or punishment for behaviour.

Safety: The OST programme should ensure the safety of clients, staff and medication. Clear information should be given to clients on the rules and regulations within the centre.

Openness and flexibility: Rules and regulations surrounding entry and retention in OST should not be overly burdensome on the client. Long waiting times, limited dispensing hours and compulsory urine testing are not recommended. Offering same-day treatment upon registration is a good practice.

Respect: High-quality care that is nonstigmatizing and nondiscriminatory is a cornerstone of effective and principled treatment.

For opioid-dependent people with TB, viral hepatitis B (HBV), HCV or HIV, it is recommended that opioid agonists be administered in conjunction with medical treatment. There is no need to wait for abstinence from opioids to start treatment for these conditions. Treatment services should offer hepatitis B vaccination to all opioid-dependent clients (whether or not they are participating in OST programmes). Care settings that provide OST should initiate HIV testing and start and maintain ART for all people living with HIV, according to national guidelines.

For more detailed information on treatment approaches, refer to the WHO *Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence* (2009).

Takeaway doses

While a period of supervised consumption with incremental dosing is essential to safe induction, there are important arguments for starting takeaway doses for clients who are stable and for whom daily supervision would impede work, study or child-care obligations. Takeaway doses may be provided for clients when the benefits of reduced frequency of attendance are considered to outweigh the risk of diversion. Clients should be responsible for using their medications according to medical recommendations.

Box 3.7

Steps in methadone treatment

Welcome by member of staff

Administrative intake of personal details

Check if individual meets intake criteria (if applicable)

Medical intake by doctor

Assessment of opioid dependence through:

- personal interview
- medical assessment
- assessment of level of dependence

Treatment plan

- Induction and calculation of starting dose (if withdrawal symptoms recur, an additional dose will be given)
- Patient kept under supervision for a few hours to check if initial dose is correct
- Patient given detailed information on the treatment and on the risks of using other drugs
- In case of co-morbidity, liaison with relevant medical services
- Stabilization period to establish the right dose

Source: Verster A, Buning E. [Methadone guidelines](#). Amsterdam: Euro-Methwork; 2000.

Box 3.8

Case example: Advocating for OST programmes in Ukraine

In Ukraine, advocacy efforts to improve access to OST were led from 2008 by the NGO Hope and Trust (Nadiya ta Dovira), an organization of parents of OST patients and people who inject drugs, working with the Association of Substitution Therapy Advocates of Ukraine (ASTAU). In the face of substantial opposition to the development of OST, and stigmatization of activists from the drug-using community, Hope and Trust started a national OST hotline and led an advocacy campaign involving informational booklets, videos, trainings and television appearances, eventually contributing to the revision of the law on OST access, and advocating successfully for the opening of 12 new OST sites.

Hope and Trust's success was helped by the social status accorded to parents in a country with traditionally strong family values, and by the influence of some members who were well known and respected in their communities. Due in part to its work, between 2008 and 2015 the number of OST patients in Ukraine almost quadrupled, to 8,300, and the number of OST sites trebled, to 167.

ASTAU and Hope and Trust collaborated to persuade authorities to permit take-home dosages of OST. These services have proven lifesaving for many individuals with complicated diagnoses. A proxy (representative of the individual), approved by the client's treating doctor, can collect the medication. In the case of intra-institutional delivery, staff communicate with drug-treatment facilities to obtain doses necessary to support those receiving in-patient treatment.

3.3.3 OST for pregnant women

Pregnant women who enter or are already on maintenance OST should be encouraged to continue treatment during their pregnancy. Long-term OST is considered the best option clinically, and women need to be informed of possible risks in opting for detoxification while pregnant. It is not uncommon to need to increase medication dosage during pregnancy due to weight gain and other physiological changes. Links to other medical and social services should be established for pregnant clients. For further information, see the WHO *Guidelines for identification and management of substance use and substance use disorders in pregnancy* (2014).

3.3.4 OST in prison

Prisoners enrolled in OST prior to imprisonment should be able to continue while in prison and after being released. The time of arrest and entry in prison for people who are on OST is particularly crucial for the continuity of treatment. To avoid interruption of treatment, a good communication system must be established between the medical services in detention and the services in the community that prescribe or dispense the OST. For example, on leaving prison, people under OST could be given a card signed by the prescriber indicating the treatment, dosage and contact details of an OST service-provider in the community to which they are returning. For more information, see also Chapter 4, Section 4.2.1.

For more information on the provision of OST in prisons, see the WHO *Clinical guidelines for withdrawal management and treatment of drug dependence in closed settings* (2009).

3.3.5 Psychosocial interventions and other evidence-based drug-dependence treatment

Brief interventions: information and counselling

The primary goal of brief interventions is to provide information about substance use, health risks, and how to reduce these risks, including by use of condoms and avoiding sharing injection equipment. Information and counselling can be conducted by trained counsellors or psychologists, by trained peer counsellors in drop-in centres or through outreach (see Chapter 4).

Cognitive behavioural therapy (CBT)

Behavioural interventions support the adoption of a health-protective attitude and lifestyle through the adoption of less risky behaviours, and enhance skills for coping with factors that could trigger risky behaviours, or relapse in the case of abstinence. CBT includes provision of psychotherapy and psychosocial support by a trained clinician. CBT can be delivered in addition to OST or in the context of abstinence-based treatment.

Withdrawal management

Withdrawal management refers to the provision of medical and psychological care to people experiencing withdrawal symptoms due to cessation or reduction of drug use. In settings where OST is not available, or in cases of non-opioid dependence, symptomatic medications should be provided to reduce the pain and discomfort of withdrawal. For clinical guidance, see the WHO *Clinical guidelines for withdrawal management and treatment of drug dependence in closed settings* (2009).

It is important that people be informed that withdrawal results in lower tolerance levels, and if the person resumes drug consumption at their usual dose after withdrawal, there is an increased risk

of overdose. For this reason, withdrawal management should be undertaken with other psychosocial support programmes.

For more information on all psychosocial interventions, please refer to WHO *mhGAP intervention guide—version 2.0* (2016).

3.4 HIV testing services

HIV testing services (HTS) are an entry point to HIV prevention services and are essential to care and life-sustaining treatment for people living with HIV. By combining counselling with knowledge of one's HIV status, HTS can help link people to harm reduction services to prevent HIV transmission, while persons living with HIV can access supportive counselling, ART, and treatment for opportunistic infections.

HTS should be part of an integrated programme of HIV prevention, care and treatment. Services should adhere to the “5 C” principles—consent, confidentiality, counselling, correct test results and connection to follow-up services. See also the WHO *Consolidated guidelines on HIV testing services* (2015). Since research and practices on different aspects of HTS are evolving rapidly, it is recommended that programme developers consult WHO for the most recent guidelines.

Rapid HIV tests can be used in community and clinical settings, either with finger-prick (whole blood) or mouth swab (oral-fluid based) samples. This may be more acceptable to people who inject drugs, who may have difficulty with venous blood access. Rapid HIV tests can be performed outside medical settings by, or with the assistance of, a trained lay volunteer or peer outreach worker.⁵ (See also Section 3.4.4.)

3.4.1 Preparation for delivering HTS

Community awareness and building demand

- Community members should be informed about the benefits of knowing one's HIV status and about the availability of effective treatment if they are diagnosed with HIV.
- Information about places where people who inject drugs can receive HTS can be distributed through harm reduction programmes, medical facilities, rehabilitation centres, telephone hot-lines and Internet forums of people who inject drugs.
- People who inject drugs should be informed of their right to confidentiality and consent and their right to refuse HIV testing if they choose.

Delivery and location of services

HTS may be provided in a variety of settings, including along outreach routes, in mobile units or temporary testing sites, at drop-in centres, NSP sites, dedicated HTS and health facilities, as well

⁵ A peer outreach worker is a person who injects drugs, or a person with community connectedness, who conducts outreach to other people who inject drugs, and who is not generally full-time staff of an HIV prevention intervention (full-time staff might be called “staff outreach workers” or simply “outreach workers”). Peer outreach workers may also be known by other terms, including “peer educators”, “community outreach workers” or “outreach workers”. However, the terms “peer” or “community” should not be understood or used to imply that they are less qualified or less capable than staff outreach workers.

as in home-based settings. Community settings may be more attractive and accessible than health-care institutions. Both the location and the timing of HTS should be responsive to the needs and requests of people who inject drugs. In some settings, this might mean providing services during evening hours or weekends, or at home through self-testing (see Section 3.4.4).

3.4.2 Delivering HTS

Pre-test information

Pre-test information can be given individually or in groups and should:

- provide basic HIV information and information about the HIV testing process
- ensure that testing is voluntary; forced or coercive testing is never warranted
- ensure that the client understands that the test result is confidential and will not be shared without their explicit consent
- provide information on follow-up prevention, ART and counselling and support services.

Note that individualized risk assessments and intensive counselling during the pre-test information session are no longer recommended by WHO, since most people receive their test results on the day of the test itself, and the prospect of intensive counselling may be a barrier to uptake of HTS.

Ensuring correct results

For specific information on how to correctly perform HIV rapid diagnostic tests and interpret test results, as well as how to use the correct HIV testing strategy and algorithm according to the setting and national guidelines, refer to the WHO *Consolidated guidelines on HIV testing services* (2015). It is important that programmes use the correct testing strategy for low-prevalence (<5%) or high-prevalence (>5%) settings with appropriate rapid diagnostic tests, in accordance with national testing algorithms.

Training, support and supervision for people carrying out HTS are essential to ensuring correct test results.

Post-test counselling

This counselling is provided when the test results are ready to be given to the client.

- Information about what is needed in the post-test counselling session may be found in the WHO publication *Delivering HIV test results and messages for re-testing and counselling in adults* (2010).
- All people, including people who inject drugs, who are found to be HIV negative should be provided with risk-reduction information specific to their individual risks, given access to condoms and lubricant, needles and syringes, and counselled on strategies to negotiate safer sex. They should be counselled about the benefits of testing for their partners.
- People who inject drugs who are found to be HIV positive should be offered immediate referral for long-term care and treatment, preferably at a clinic or hospital whose staff are respectful of people who inject drugs. Community-based case management or peer navigation could facilitate treatment initiation and adherence support for people who inject drugs. They should also receive counselling about how to avoid transmitting HIV to others, including being provided with condoms, and they should also be counselled about the benefits of testing for their partners and family members, and offered support in notifying partners.

- It is important to assess for mental-health issues, such as anxiety and depression, and refer people to a specialist if needed. (See also Section 3.13.)

Repeat testing

- People who inject drugs who test HIV negative should be advised about the importance of re-testing every six months or annually, depending on their risk profile.
- Repeat HIV testing should also be offered whenever there is a new STI diagnosis.
- Individuals with potential exposure to HIV in the past three months should be advised to re-test.
- An individual with a discrepant test result should be referred for re-testing in 14 days.
- HIV positive individuals should be re-tested prior to initiating treatment. This can be done at community clinics that do clinical assessments, initiate and deliver ART and provide services to pregnant women or other populations that may initiate treatment immediately regardless of their CD4 count.
- If people come for HTS within 72 hours of a potential exposure, provision of post-exposure prophylaxis (PEP) should be considered. For more information, see the WHO *Guidelines on post-exposure prophylaxis for HIV and the use of co-trimoxazole prophylaxis for HIV-related infections among adults, adolescents and children* (2014).

3.4.3 Pre-exposure prophylaxis (PrEP)

For all key populations, WHO recommends offering PrEP to people at substantial risk of HIV infection, as part of combination prevention approaches. For people who inject drugs, the priority interventions for HIV prevention remain covered by harm reduction, in particular NSP and OST for those who are opioid-dependent. These are the most effective interventions in preventing HIV and other bloodborne infections. Consideration should be given to providing PrEP to prevent sexual transmission of HIV, including to sexual partners of PWID living with HIV who are not virally suppressed on ART. For more information, see the WHO *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations–2016 update* and the INPUD *Background document: an introduction to pre-exposure prophylaxis (PrEP) for people who inject drugs* (2015).

3.4.4 Other approaches to testing

HIV self-testing

HIV self-testing is a process in which an individual who wants to know his or her HIV status collects a specimen, performs a test and interprets the result by him or herself, often in private. Self-testing does not provide a definitive diagnosis. A reactive (positive) self-test result always requires further testing by a health-care worker to confirm the result. For further information, see the WHO *Guidelines on HIV self-testing and partner notification* (2016).

HTS performed by peer outreach workers or lay providers

HTS are often more acceptable to people who inject drugs when performed by a trusted community member, i.e. another person who injects drugs. Peer outreach workers can be an effective part of the voluntary HTS workforce. Adequate training, ongoing support and monitoring are essential for all personnel performing HIV testing at the community level, including health workers, programme staff and peer outreach workers. (See also the WHO policy brief *WHO recommends HIV testing by lay providers* [2015].)

Partners and family testing

When a person tests HIV positive, it is often helpful to offer voluntary testing of their sexual or injecting partners, spouses and family members. People who inject drugs living with HIV should be supported to disclose their results to their partners, trusted family members, and HTS should be available to their partners, children and other family members.

3.5 Antiretroviral therapy

The increased availability of, and access to, ART has significantly decreased HIV-related illness and death. Recent advances in HIV treatment, coupled with advocacy for increased availability of affordable drugs, have resulted in substantial improvements in the quality of life of people living with HIV throughout the world. However, while global levels of treatment coverage have increased substantially over the last years, access among people who inject drugs is still very low, with a global average of less than 10%.

3.5.1 Treatment initiation

WHO guidelines recommend starting ART for all people with HIV, regardless of WHO clinical stage and at any CD4 cell count, including people who inject drugs with HIV. As a priority ART should be initiated in all individuals with severe or advanced HIV clinical disease (WHO clinical stage 3 or 4) and individuals with CD4 counts of ≤ 350 cells/mm³. Priority should be given to the following people, regardless of WHO clinical stage or CD4 count:

- individuals with HIV and active TB disease
- individuals co-infected with HIV and HBV or HCV with evidence of severe chronic liver disease
- partners with HIV in serodiscordant couples, to reduce HIV transmission to uninfected partners
- pregnant and breastfeeding women.

It is recommended that programme developers consult WHO for the most recent guidelines.

3.5.2 Adherence support

With adequate and sustained support, people who inject drugs have similar adherence results to other ART clients. OST is an enabling factor for ART adherence among people who are dependent on opioids, and WHO recommends provision of ART in OST clinics. There are several strategies for effective adherence support programmes:

- “Intensive” adherence support for the first six months of therapy, when maximum attention must be given to the client.
- The community or peer counsellor can conduct an initial interview and risk assessment, offer adherence support during the intensive case management phase, and identify “dropouts” to offer them encouragement. Feedback from the community or peer counsellor to the multidisciplinary team is a crucial part of case management.
- Like many people beginning ART, people who inject drugs may have fears and concerns about the treatment. Knowledge of current community understanding of ART is imperative to address concerns, fears or misconceptions with accurate and appropriate information. Counselling should include why it is beneficial to initiate ART before feeling unwell or having symptoms. Adherence, maintaining a suppressed viral load to support good health and prevent treatment

failure, as well as the benefit of ART in reducing risk of HIV transmission, should be fully discussed. This may happen over several sessions. The potential benefits of treatment preventing transmission of HIV to sex partners should be specifically discussed.

- Clients who drop out of treatment require priority attention with a detailed assessment of the factors that led to treatment termination and diligent attempts to re-engage them in treatment.
- Establish a system to ensure the continuity of treatment for people who are in detention or in prisons, including upon their release.

3.5.3 Managing contraindications

Interactions between ART, TB, HBV, HCV and OST medicines are addressed in HIV treatment guidelines (see Section 3.14). Ensuring effective collaboration and coordination between hepatitis, TB, ART and OST services will enable monitoring of possible withdrawal symptoms in clients who begin ART while on OST or TB treatment. If medications precipitate withdrawal, the dose adjustments should follow WHO or national guidelines. (See also Section 3.3.)

3.5.4 Overcoming barriers to ART access for people who inject drugs

Access to HIV screening with enrolment into care remains the weakest point in the continuum of services for people who inject drugs. Increasing the availability of HIV rapid testing performed by health-care workers and peer outreach workers should be a priority (Section 3.4.4). A case management approach to treating HIV positive people who inject drugs, and service integration, will also help (see Chapter 4, Section 4.2.2).

Effective collaboration between the health-care system and outreach projects can help ensure services are as accessible as possible to clients, for example by:

- offering blood sampling for CD4-cells and viral load tests at outreach spots (mobile clinics), NSPs, or drop-in centres
- organizing clinical check-up days in mobile clinics, NSPs or drop-in centres.

3.6 Sexually transmitted infection services

Provision of basic HIV and STI clinical services is an essential component of a comprehensive package of services for people who inject drugs. Programmes should work to enhance STI care-seeking behaviour as a community norm: people who inject drugs and their sexual partners should know the symptoms of STIs and be encouraged to seek care promptly. Moreover, they should be aware that STIs are commonly asymptomatic and thus be encouraged to undergo regular STI screening. Linking STI services to other, community-led services, and involving people who inject drugs as service planners, implementers and providers, helps achieve this.

People who inject drugs, particularly women, adolescents and young people,⁶ and men who have sex with men, may sell sex to support their drug use. This increases the risk of violence, including sexual violence, and their likelihood of acquiring STIs.

⁶ Young people who use or inject drugs are those in the age range 10–24 years, in accordance with the Interagency Working Group on Key Populations *HIV and young people who inject drugs: a technical brief* (Geneva: World Health Organization; 2015).

3.6.1 Designing STI services

STI services for people who inject drugs and their sexual partners should meet basic standards of quantity and quality. They should also address the sexual-health needs of people who sell sex or who have unprotected anal sex. Components of an STI service package are:

- Screen and treat for common STIs (e.g. syphilis, chlamydia, gonorrhea—for further information see the 2016 WHO [clinical guidelines](#) for these infections).
- Make a diagnosis of an STI (etiologic [lab] or syndromic).
- Provide treatment (etiologic or syndromic, as appropriate).
- Provide information.
- Enhance or ensure partner notification and management.
- Promote and provide condoms and lubricant.
- Assess client's perceptions of risk and counsel on safer sex.
- Arrange follow-up.
- Provide confidential HTS.

3.6.2 Organizing STI services

It is important that the STI service package be integrated with HIV, sexual and reproductive health (SRH) and primary care. Coordination and referral mechanisms between harm reduction and STI services should be identified. In the case of a positive rapid STI test, the individual is referred to a medical facility for diagnosis and treatment. Upon request, the individual may be accompanied to the service by a social worker or peer outreach worker. Mobile ambulatory staff may include a physician trained on STIs, nurse, social worker and driver.

Table 3.1 Provision of STI services through different delivery models

Community-based services via implementing organization⁷ (at fixed NSP sites, drop-in centres)	• Counselling and rapid testing for HIV • Counselling, risk assessment for STIs, syndromic STI management and rapid testing for syphilis • Social worker counselling and support • Provision of condoms and lubricant and advice on their use • Community education to improve knowledge on STIs
Health-care facility	• Screening for STIs • STI case management (etiologic or syndromic) a) History, risk assessment and physical examination; b) Full laboratory diagnosis (if feasible) c) Diagnosis and treatment; d) Counselling; e) Condoms and lubricant; f) Partner management g) Follow-up; h) HTS
Mobile service (van or bus)	• Counselling and rapid testing for HIV • Counselling, risk assessment for STIs and syndromic management and rapid testing for syphilis • Counselling and testing for hepatitis B and C • Consultation with social worker issuing condoms and lubricant, syringes, alcohol wipes

⁷ An implementing organization is an organization delivering an intervention to people who inject drugs, with a client-centred approach. It may be a governmental, nongovernmental, community-based or community-led organization, and may work at a state, provincial, district or local level. Sometimes a nongovernmental organization provides services through subunits at multiple locations within an urban area, and in this case, each of those subunits may also be considered an implementing organization.

3.7 Sexual and reproductive health and rights

People who inject drugs and their sexual partners have the same need for a full range of sexual and reproductive health (SRH) services as other people, extending beyond STIs and HIV, but these needs are often overlooked by harm reduction programmes. Staff of harm reduction services, as well as those of mainstream services, should be trained and supported to understand the SRH needs and rights of people who inject drugs so that appropriate and relevant services can be developed and delivered.

3.7.1 Family planning and contraceptive counselling

The basic steps in ensuring contraceptive choices including family planning and contraceptive counselling for people who inject drugs and their partners are:

- Establish whether a client wants to have children, and how many children the client hopes to have.
- Discuss preventing and treating infertility as needed.
- Discuss advantages and disadvantages of available contraceptive options, including condoms which provide protection against HIV, STIs and unintended pregnancies. Discuss dual protection—use of condoms plus another contraceptive method to ensure more effective prevention of pregnancy—and discuss the side-effects of each contraceptive method.
- Determine client preference and medical eligibility for the desired contraceptive method, provide counselling on its use, and supply the actual contraceptive, or a prescription if needed.
- Discuss how to prevent sexual and drug-related transmission of HIV, including PrEP and PEP, and provide access to male and female condoms and lubricant, and education on their correct use and on condom negotiation skills.

Drug use can influence a woman's menstrual cycle, causing menstruation to become irregular or to stop. Women should be informed that this does not prevent them from becoming pregnant (as the ovulation cycle can start at any time) and that if they do not wish to become pregnant they need contraception.

Emergency contraception may be provided to a woman who has had unprotected vaginal sex, is not currently using a contraceptive method and is not pregnant. It should be provided on request as soon as possible after unprotected sex, ideally within 72 hours, with a limit of 120 hours. (Effectiveness is reduced beyond 72 hours.)

Reproductive tract cancer screening

Cervical cancer screening promotes early detection of precancerous and cancerous cervical lesions and prevents serious morbidity and mortality. It is recommended that cervical screening be performed for every woman aged 30–49 at least once in her lifetime. Screening may be done through visual inspection with conventional Pap smear or HPV (human papilloma virus) testing. Pre-cancerous and cancerous lesions should be treated immediately.

Women who are living with HIV should be screened for cervical cancer regardless of age. Priority should be given to maximizing coverage of the risk age group and to ensuring complete follow-up of women with abnormal screening test results.

Screening for other cancers

Screening for breast cancer, ano-rectal and prostate cancer should be part of routine care, and links to treatment services should be provided.

3.7.2 Pregnancy testing and pre- and postnatal care

If a woman who injects drugs believes she is pregnant, this should be confirmed with a pregnancy test. If confirmed, the woman should be referred for prenatal care—to manage her drug use during pregnancy, to monitor for any complications of pregnancy, to improve the pregnancy outcome and for the general health and well-being of both mother and infant. For further information, see the WHO *Guidelines for identification and management of substance use and substance use disorders in pregnancy* (2014). Postnatal care continues after birth to ensure mother and baby continue to do well and receive routine follow-up services such as immunizations, and any further care and support as needed. Pre- and postnatal care are especially important for women who inject drugs to provide support and guidance on the best options in terms of continued drug use, substitution therapy or cessation of drug use during or after pregnancy. This guidance should be offered to support the woman in making her own voluntary and informed decision on the best course of action for herself and her infant. Pre- and postnatal care are also important for women living with HIV to prevent transmission of HIV and other STIs to infants during pregnancy, delivery or breastfeeding.

Box 3.9

Considerations for prenatal care for women who inject drugs

- Service-providers, including outreach workers, harm reduction services, drug-treatment providers and antenatal care services must be adequately informed about drug use and pregnancy, in order to provide appropriate information to pregnant women who inject drugs. Harm reduction services should advocate with obstetric services to provide nonpunitive, factual education and care to pregnant women and nursing mothers to protect their health and that of their infants.
- It is not uncommon for women who inject drugs to have irregular or absent periods, and they may not realize that they are pregnant until late into their second or even third trimester. It is therefore important that harm reduction service staff educate women who inject drugs on the potential benefits of prenatal care for pregnant women and their babies, and provide home pregnancy test kits.
- Women may not be fully aware of the potential impact of drugs on the child during pregnancy and breastfeeding, and may have misconceptions about drug use and pregnancy. They should be provided with accurate and relevant information regarding the risks and harms to pregnancy associated with the continuing use of specific drugs, including tobacco and alcohol.
- While the use of any drug while pregnant should be avoided, this may not be a realistic option. Given that many women experience heightened stigma if pregnant and using drugs, which can discourage them from seeking services, it is essential that workers provide support in a nonjudgemental manner to pregnant women who continue to use drugs.
- Heroin users should be advised of the dangers of abrupt opioid withdrawal to the foetus, and referral to OST should be encouraged.
- Pregnant women living with HIV should receive ART and syphilis testing and treatment as needed, to maintain their own health and reduce mother-to-child transmission of HIV and syphilis.

Pregnant women who enter or are already on maintenance OST should be encouraged to continue in treatment while pregnant. Maternal and infant health services should include:

- information on infant feeding options, nutritional counselling and support
- health information and education around HIV and HIV prevention, safer sex, PrEP, PEP, ART as prevention, and guidance on breastfeeding (see Box 3.9), as well as prevention of syphilis, viral hepatitis and TB
- For women living with HIV, provide ART (either on-site or by referral), HIV treatment, care and support for both mother, child, and partner, and on-site or by referral for prophylaxis and treatment of HIV-related conditions, including TB. ART adherence and other types of counselling and support are also important.

For guidelines on breastfeeding for women living with HIV, see the WHO guideline *Updates on HIV and infant feeding* (2016).

Box 3.10

Case example: Care for pregnant women who use drugs in Canada

SHEWAY in Vancouver provides essential education and nutrition to pregnant women who use drugs, while adapting to whatever choice of drug or treatment the woman might decide on. For mothers who chose to continue using street drugs, the programme focuses on nutrition and on making better choices about the quality of street drugs they are using, while for others various substitution therapies are offered. By focusing on the best possible outcomes for mother and baby, SHEWAY delivers services that accommodate better birth outcomes and eliminate the experience of violence for women who use drugs who are giving birth.

www.sheway.vcn.bc.ca

3.7.3 Abortion and post-abortion care

Where abortion is legal, links to safe abortion services should be established, but the decisions regarding abortion should always be voluntary on the part of the woman. Where abortion is illegal, women who inject drugs should be informed about the risks of informal abortion methods. Women who inject drugs should have access to appropriate post-abortion care to reduce related morbidity and mortality, and care for post-abortion complications such as infection and excessive bleeding should be provided.

3.7.4 Clinical care for survivors of sexual assault

Where possible, clinical care for survivors of sexual assault should be linked with community-based responses to violence. Full details of clinical care protocols can be found in the WHO clinical and policy guidelines on *Responding to intimate partner violence and sexual violence against women* (2013). First-line support to survivors of sexual assault includes:

- Provide practical care and respond to women's emotional, physical, safety and support needs without intruding on privacy.

- Listen and enquire about needs and concerns, validate what women are feeling, enhance safety and support.
- Provide physical care:
 - Treat physical injuries
 - Take a complete history to determine what interventions are appropriate, and conduct a complete physical examination.
- Offer emergency contraception to women presenting within five days of sexual assault.
- Consider offering PEP for people who inject drugs presenting within 72 hours of a sexual assault. Use shared decision-making with the survivor to determine whether PEP is appropriate.
- Offer prophylaxis for chlamydia, gonorrhoea, trichomonas and syphilis (depending on the local prevalence). The choice of drug and regimens should follow national guidelines.
- Offer hepatitis B vaccination without hepatitis B immunoglobulin, as per national guidelines.
- Offer psychological support and care, including coping strategies for dealing with severe trauma, using evidence-based mental-health services that are accessible, available and follow the WHO *mhGAP intervention guide—version 2.0* (2016). Assess the client's needs for mental-health services again at three months following the assault.

3.7.5 Services for sex workers who inject drugs

Harm reduction and sex worker services should be closely linked with SRH services. For more information, see *Implementing comprehensive HIV/STI programmes with sex workers: practical approaches from collaborative interventions* (2013—the SWIT) and the International Network of People Who Use Drugs (INPUD) and Global Network of Sex Work Projects (NSWP) publication *Sex workers who use drugs: ensuring a joint approach* (2015).

3.8 Condom and lubricant programmes for people who inject drugs and their sexual partners

The effective supply, distribution and promotion of male and female condoms and condom-compatible lubricants is essential to successful HIV prevention interventions. Condoms have been recommended as an HIV prevention method since the mid-1980s and remain a very effective tool in preventing the sexual transmission of HIV.

For detailed guidance, see the United Nations Population Fund's (UNFPA) *Comprehensive condom programming: a guide for resource mobilization and country programming* (2011) and *Condom programming for HIV prevention: a manual for service providers* (2005) as well as relevant sections in Chapter 3 of *Implementing comprehensive HIV/STI programmes with sex workers: practical approaches from collaborative interventions* (2013—the SWIT).

Strategic partnerships are essential to improve access to, and use of, condoms and lubricant for triple protection against unintended pregnancies, STIs and HIV. Partners include organizations led by people who inject drugs, NGOs, the Ministry of Health or national AIDS programme, United Nations (UN) agencies, the private sector, social marketing organizations, donor agencies and law-enforcement ministries.

Effective, comprehensive condom and lubricant programming involves the following:

- The process is ideally led and owned by the government in partnership with implementing organizations and organizations of people who use drugs, and efforts are coordinated through sound leadership at the national level.
- Demand for condoms and lubricants is created and sustained.
- Adequate supplies of high-quality condoms and lubricants are available and distributed widely.
- An outreach approach is used for distribution to ensure access to condoms and lubricants at the community level.
- Types and quantity of condoms and lubricants are provided in response to the stated needs and preferences of people who inject drugs. A wide range of male and female condoms is available.
- Where people who inject drugs are engaging in sex work, it is important that law-enforcement officers do not use condoms as evidence of sex work. Stopping and searching sex workers for condoms makes them less likely to carry and use them.
- Advocacy and capacity-building are carried out to ensure a supportive environment for the sustainability of the programme over the long term.
- A monitoring and evaluation system is established to ensure effectiveness of condom and lubricant distribution programmes.

Female condoms

The female condom is an important preventive commodity for women who inject drugs and should be promoted strongly. This requires the skills to demonstrate its correct use as well as an understanding of its advantages:

- It is useful during menstruation.
- It can be used when the male partner cannot maintain an erection.
- It requires less cooperation from the partner and therefore increases the woman's control over the use of contraception.

Peer outreach workers should be trained to demonstrate correct use of the female condom and should be given female pelvic models to use in these demonstrations, as well as supporting informational materials. Note that female condoms are single-use commodities and should not be re-used.

3.9 Targeted information, education and communication

Harm reduction programming involves efforts to change knowledge, attitudes, beliefs and behaviour, as well as build community solidarity. Information, education and communication (IEC) materials can complement and add value to these interventions. IEC materials, whether printed or electronic, can be shared from person to person without loss or misinterpretation of information.

3.9.1 Creating effective IEC materials for people who inject drugs

Involve the right people: A team approach is needed, including people with knowledge of evidence-based medical and public-health practices, as well as people with skills in design, editing and proofreading. It is also essential to meaningfully involve people who inject drugs (specifically people from the community targeted by the particular material) in the process of planning, developing, designing, testing and distributing the materials, and evaluating their effectiveness.

Take into account the knowledge, beliefs, attitudes, practices and needs among your target audience: Research the knowledge, attitudes and practices of the people who should benefit from the IEC materials planned. Focus group discussions are very useful to collect this information before developing the material. Written materials should use language that is easily understandable by the target community, including terminology common to the community (e.g. slang).

Don't reinvent the wheel: Examine materials that have been used by other programmes: they may require adaptation to the local context, but time and money can sometimes be saved by modelling materials on pre-existing ones. It is important to ask permission from the original creators and to acknowledge the source.

Take the sensitivities of the wider community into account: The materials may be seen by people other than people who inject drugs, including family members, local authorities, religious leaders and the police. When working on building consensus in the wider community about harm reduction services, it may be helpful to discuss the IEC materials that will be distributed, or to share drafts with partners before publication.

Box 3.11

Steps in creating IEC materials

1. **Identify a clear purpose.** Any material to be developed should have a specific learning or behaviour change objective. It is important to differentiate between the purpose of an overall informational campaign and the purpose of the specific IEC materials.
2. **Identify a clear target audience.** People using the materials may not be a homogenous group. Subgroups with differing knowledge, beliefs, practices and tastes should be taken into account. It may not be possible to use one version of a particular IEC material throughout a country or even throughout a single city.
3. **Organize focus group discussions with representatives of the targeted (sub)groups.**
4. **Develop the key message** in a short and clear form.
5. **Identify the best format** for the message, bearing in mind the content, target audience and available resources for production and dissemination.
6. **Develop a dissemination plan**, which may include estimating the number of publications and how materials will be disseminated.
7. **Design the materials.** Make sure that printed materials are in a convenient format, e.g. pocket-sized so that they can be carried discreetly.
8. **Test the materials** with a focus group of community members. Be prepared to change the text and design based on the feedback.
9. **Proofread the publication** before and after it is laid out.
10. **Publish and disseminate!**
11. **Monitor and evaluate** the materials. This can help you understand which items are popular and accepted, and why.

3.9.2 IEC materials and community mobilization

Giving people who inject drugs the opportunity to lead in producing materials (websites, newsletters, video documentaries, IEC etc.) can be very empowering. The production of periodic newsletters or regular maintenance of websites and social media sites can bring people together and create a forum for creative expression, as well as be places where people can be informed about and discuss emerging health and rights issues.

3.10 Prevention, vaccination, diagnosis and treatment of viral hepatitis

HBV and HCV disproportionately affect people who inject drugs, with a prevalence of HCV estimated at 52% worldwide.⁸ Among people who inject drugs who are living with HIV, co-infection with HCV has been estimated globally to be 82% (55–89%), illustrating the risk of bloodborne virus transmission via sharing of injecting equipment.⁹ HIV–HCV co-infection alters the course of both diseases. HIV can accelerate HCV disease and increase HCV-related mortality.

HBV is preventable through vaccination, and treatment is effective in reversing liver disease and preventing liver cancer. There is currently no vaccination for HCV. Unlike HIV, HCV is curable with the appropriate medications.

3.10.1 Prevention

Both HCV and HBV are preventable through combined harm reduction interventions. In the case of HCV in particular, high coverage levels and high-quality NSP and OST play an important role in reducing transmission. People who have been spontaneously or medically cured from hepatitis C are not completely protected against a new hepatitis infection.

Since sharing drug use equipment such as cookers and filters may contribute strongly to HCV transmission, these items should be included in harm reduction sterile kits. Additionally, non-injecting drug users, such as crack smokers, may be at higher risk of HCV transmission through sharing smoking equipment (pipes). Noninjection equipment should be considered for distribution to this population.

The WHO *Guidance on the prevention of viral hepatitis B and C among people who inject drugs* (2012) recommends:

- offering people who inject drugs the rapid hepatitis B vaccination regimen. Priority should be given to the first dose of the vaccination schedule.
- offering incentives to increase uptake and completion of the hepatitis B vaccine schedule by people who inject drugs
- that NSPs also provide low-dead-space syringes for distribution to people who inject drugs
- offering peer interventions to people who inject drugs to reduce the incidence of HBV and HCV; interventions to prevent HBV and HCV among people who inject drugs should be flexible and pragmatic, making use of opportunistic contact with the target population.

⁸ *World drug report 2016*. Vienna: United Nations Office on Drugs and Crime; 2016.

⁹ Platt L, Easterbrook P, Gower E, et al. *Prevalence and burden of HCV co-infection in people living with HIV: a global systematic review and meta-analysis*. *Lancet Infectious Diseases*. 2016;16(7):797–808.

3.10.2 HBV and HCV screening and testing

As a population with a high risk of infection, people who inject drugs should be offered screening for HBV and HCV as an integral component of the comprehensive package of harm reduction interventions, in accordance with WHO and national guidance. Repeated testing may be required in people with ongoing risk.

In order to confirm HCV infection, an RNA test is required. Testing must be noncoercive and voluntary, and the client must understand the implications of the testing process. It is important to focus on what can be known, provided and offered. For example, in the case of a positive HCV antibody test, clients may be informed about the evolution of chronic hepatitis C, the main signs of advanced liver disease, the importance of confirming chronic HCV through RNA testing, the potential risk of transmission to others, the risks of alcohol use, and the effects/side-effects of OST and other treatment programmes, including curative antiviral therapy.

3.10.3 Treatment

HBV and HCV treatment are as effective among people who inject drugs as in other populations, especially if specific adherence and psychosocial support is provided. Therefore, people who inject drugs who have HBV or HCV should be offered treatment without any discrimination.

The treatment of HIV in people who inject drugs living with chronic HBV or HCV may reduce the progression of liver disease, so effective ART is recommended regardless of CD4 count. Coordination between hepatitis and HIV health-providers and OST clinics is crucial, and integrated care is ideal. Adequate training should be given to health-service providers to strengthen their knowledge and capacity to prevent, diagnose, educate and treat HBV and HCV in people who inject drugs, so that they can adequately support those with the disease.

HBV and HCV treatment may interact with treatments for other bloodborne viruses as well as with OST. Treatment interactions are an important consideration in order to avoid side-effects and increase effectiveness.

In order to potentially improve HBV and HCV treatment adherence and outcomes, people who inject drugs may be assessed for eligibility in OST and in other service settings. Additionally, adherence may be increased through emotional, social and practical support by multidisciplinary teams, including peer workers. People who have been treated for HCV can play a valuable role in health-care engagement and treatment support, and peer interventions have been an important source of support in HCV prevention, care and treatment.

For the treatment of HCV, WHO recommends new, combination direct acting antiviral (DAA) therapy with all oral medicines for at least 12 weeks. The effectiveness of new DAAs is less affected by genotype and HIV status, although DAAs are less effective in advanced liver disease such as cirrhosis.

For more guidance see WHO's 2016 *Guidelines for the screening, care and treatment of persons with chronic hepatitis C infection* (2016) and the *Guidelines for the prevention, care and treatment of persons with chronic Hepatitis B infection* (2015).

3.10.4 Implementation considerations

Outreach programmes, NSPs, drop-in centres and all service-providers should make sure that people who inject drugs are properly informed about the different kinds of hepatitis, risks of transmission, and prevention and treatment.

Hepatitis B vaccination

All people who inject drugs should be vaccinated against hepatitis B. Vaccination should be provided at drop-in centres or NSPs to optimize access for people who inject drugs. It should also be offered in drug-dependence centres, OST clinics, HIV clinics and other services attended by people who inject drugs.

Offering small financial or other incentives is associated with higher HBV vaccination completion rates among people who inject drugs. This recommendation applies to settings with lower vaccination uptake rates among people who inject drugs, and where other efforts to increase vaccination uptake are already in place. For further information, see the WHO *Guidance on prevention of viral hepatitis B and C among people who inject drugs* (2012).

Women

Women who use drugs are often affected even more negatively than men by viral hepatitis because of poor access to gender-sensitive harm reduction services. Prevention messages should be targeted to reflect the specific situations and contexts in which women use drugs. Women in general, including those who use drugs, are an important priority for treating chronic hepatitis during pregnancy.

Young people

Young people are a high-risk group because of lack of information and the barriers they face to accessing health care. Harm reduction and HCV efforts should specifically target young people, and messages and programmes should be developed with their input in order to increase uptake. Adolescents and youth are currently often excluded from treatment in many countries. This increases the risk of transmission. They should be a target population for treatment. For more information, see the technical brief on *HIV and young people who inject drugs* (2015).

3.11 Tuberculosis prevention, diagnosis and treatment

Despite being preventable and curable, tuberculosis (TB) is the leading cause of HIV-related mortality, accounting for almost a third of all HIV-related deaths. Evidence linking TB and drug use primarily relates to injecting drug use, but an increased risk of TB has also been linked to smoking crack cocaine and opium.

There is a growing body of evidence that suggests an association between HIV, injecting drug use and multidrug resistant TB (MDR-TB), particularly in Eastern Europe. Clients with MDR-TB, and in particular HIV-associated MDR-TB, have poor treatment outcomes and high mortality rates.

In countries with a high TB burden it has been estimated that two-thirds of people who inject drugs who have TB also have HCV. Detailed recommendations can be found in WHO's consolidated guidelines on *Integrating collaborative TB and HIV services within a comprehensive package of care for people who inject drugs* (2016).

Box 3.12

Case example: Integrating hepatitis care into harm reduction in Ukraine

The Alliance for Public Health's strategy on hepatitis prevention and treatment for people who inject drugs includes collecting prevalence data via regular screenings, integrating a hepatitis component in harm reduction programmes, working with medical professionals (trainings, workshops on hepatitis testing, treatment and care), awareness and mobilization campaigns, and an advocacy campaign to expand access to treatment for vulnerable groups. The Alliance works with state and local hepatitis programmes, pharmaceutical companies (on price reduction for diagnostics and treatment), the general population and vulnerable groups (on hepatitis awareness and generating treatment demand).

An integrated treatment model for HCV has been developed, with HIV centres that provide OST also carrying out diagnostics and treatment of HCV in collaboration with hepatological centres. NGO case managers ensure that clients are linked to services and to psychosocial support from community-based organizations, including peer consultations, counselling client's relatives, and assistance in receiving ART and OST. The initial treatment programme began in late 2013 for 154 HIV/HCV co-infected OST clients in 10 regions of Ukraine. The programme was facilitated by considerable price reductions for diagnostics and treatment, and there are plans to expand the treatment programme to serve 1,500 clients.

As of June 2015, the Alliance implemented the first national-level DAA-based HCV treatment programme through a community-supported treatment model. Alliance is implementing the programme in 14 regions of Ukraine and across 19 health facilities, in cooperation with 14 regional NGOs. The model of integrated medical and social support includes elements of case management and interventions to prevent reinfection. Of the 1,170 clients who have so far received treatment across the 14 regions, 96% were co-infected with HCV and HIV, and 99% of these received ART. The Alliance has also been successful in influencing government policy. For instance, DAA-based treatment regimens are now included in the National Clinical Guidelines for Hepatitis C treatment.

3.11.1 Screening, diagnosis and treatment of latent TB infection

All people living with HIV should be screened regularly with the WHO-recommended four-symptom TB screening algorithm (Figure 3.1). This screening helps to determine eligibility for treatment of latent TB infection—e.g. with isoniazid preventive therapy (IPT)—by ruling out the likelihood of active TB, and to identify those who need further evaluation, diagnosis and treatment for TB as necessary. WHO recommends using Xpert MTB/RIF as the first diagnostic test for active TB in all people living with HIV and for anyone suspected of MDR-TB. Programmes supporting people who inject drugs can offer gateways to early TB detection and timely prevention and treatment of both TB and HIV. It is crucial, therefore, that personnel are aware of the symptoms of TB. For more information, see the WHO guidelines on *Intensified tuberculosis case finding and isoniazid preventive therapy for people living with HIV in resource constrained settings* (2011).

IPT can be tolerated by people who inject drugs who are living with HIV and are co-infected with HBV or HCV, without creating drug-induced hepatitis (DIH). However, excessive use of alcohol has been identified as a risk factor for DIH, so liver function needs assessment and monitoring.

Figure 3.1 TB symptom screening tool for people who inject drugs living with HIV

Are any of the following symptoms present? • Current cough • Fever • Night sweats • Weight loss	Yes	Xpert MTB/RIF for first diagnostic test	TB diagnosis?	Yes	TB treatment, followed by ART 2–8 weeks after initiation of TB treatment
	No	Offer IPT for latent TB infection (after assessing contraindications and eligibility)		No	Offer IPT for latent TB infection (after assessing contraindications and eligibility)

Systematic screening for TB using other methods such as X-ray, according to national guidelines, is also recommended among people who inject drugs not living with HIV, in countries where the TB prevalence is high (100 per 100,000 population or higher). Systematic TB screening in prisons and other closed settings should also be conducted where prevalence of TB, MDR-TB or HIV is high in the general or prison population. Algorithms for prisoners and people who inject drugs not living with HIV can be found in the WHO *Systematic screening for active tuberculosis: principles and recommendations* (2013).

Box 3.13

Case example: Offering TB services as part of harm reduction in Afghanistan

A harm reduction implemented by Médecins du Monde (MdM) via professional and peer outreach workers built the capacity of people who inject drugs to reduce the risks related to their drug use through a range of services. OST was used as a starting point to engage, assess and stabilize clients. The seven-day-a-week methadone dispensing service provides a platform for delivering a range of other health-care interventions, including ART and TB treatment. This promoted high levels of treatment engagement and compliance despite the difficult service setting. Key features of MdM's service in Kabul included:

- All people attending the service were offered TB screening and education about TB.
- TB treatment was integrated alongside the daily dispensing of methadone and provision of ART for people also living with HIV.
- Routine monitoring of TB was included in the medical review of OST clients.
- MdM was able to access advanced analysis of TB tests in the mainstream health service.
- Clients requiring more advanced treatment were referred to general medical services (although stigma and discrimination against people who inject drugs posed barriers to a fully integrated service).

Although the MdM programme is no longer in operation, local harm reduction organizations continue to provide services to people who inject drugs, and one of the MdM's main partners is scaling up methadone maintenance therapy. Numerous trained peer outreach workers still take part in advocacy initiatives, and with the support of Bridge Hope and Health Organization, a local NGO, one of the groups of people who use drugs has become an officially recognized organization that represents the community at the government level.

3.11.2 Treatment

Treatment of drug-sensitive TB consists of a standardized rifampicin- or rifabutin-based regimen for at least six months, irrespective of HIV status. It is crucial that the TB treatment is completed, both to reduce mortality and to avoid the development and spread of drug-resistant TB. For more information, see the WHO *Guidelines for treatment of tuberculosis* (2010).

People who inject drugs who have a history of TB treatment interruption or of incarceration could be at higher risk of MDR-TB. Guidance on the management of MDR-TB and extensively drug-resistant TB (XDR-TB) can be found in the *Guidelines for the programmatic management of drug-resistant tuberculosis*.

Box 3.14

Case example: TB services in the context of HIV prevention and harm reduction in Belarus

TB, HIV and drug-dependence services in Belarus used to be delivered via separate programmes, each with its own administration, financing and staff. This was a barrier to people accessing ART after being diagnosed with TB, and many of these people injected drugs. Belarus responded by allowing ART to be initiated in TB clinics; however, people were still not able to start OST while in TB hospitals. This changed after a national consultation in early 2012 that recommended initiating OST in TB clinics, with financial support from the Global Fund and the Belarus Ministry of Health.

Some TB clinics have created positions for narcologists or made arrangements for consultancy services. One TB hospital plans to operate a permanent distribution site for OST, which would support stronger integration of services. The new approach is driving the expansion of the OST programmes in Belarus.

Source: WHO, UNICEF, UNAIDS. *Global update on HIV treatment 2013: results, impact and opportunities*

ART during TB treatment

Starting ART promptly significantly reduces the risk of mortality from TB associated with HIV. All people who inject drugs with suspected or diagnosed TB should be offered HTS as a priority so that those testing positive can start ART as soon as possible. ART should begin no later than eight weeks after the start of TB treatment, regardless of CD4 count. HIV positive people who inject drugs who have very compromised immune systems (CD4 <50 cells/mm³) should begin ART within two weeks of starting TB treatment.

Drug interactions

Rifampicin can independently decrease methadone concentration levels in the blood, which, depending on the individual, may cause withdrawal and increase the risk of relapse to opioid use. Findings also indicate possible increased opiate withdrawal associated with interaction between rifampicin and buprenorphine. As an alternative to rifampicin, rifabutin may be used, as this is not

documented to significantly affect buprenorphine or methadone levels. Clients receiving methadone or buprenorphine and rifampicin should be monitored closely, and those experiencing opioid withdrawal will need to have their OST doses adjusted according to the individual's needs. In all cases, the client and the OST prescriber should be advised of potential interactions. Flexible dosing regulations and policies are particularly important for opioid-dependent people who inject drugs who are diagnosed with TB.

3.11.3 Encouraging adherence

People who inject drugs who are adequately supported can achieve adherence and clinical outcomes comparable with people who do not use drugs. Adherence improves with directly observed therapy, adherence reminders, peer counselling, contingency management, monetary incentives, and through an integrated package of care that includes OST and attends to the psychosocial as well as health-care needs of people who inject drugs.

Box 3.15

The role of community-based support for TB treatment and adherence

Community organizations and networks play a key role in ensuring access to and engagement in TB services and supporting access to treatment and prevention services. Self-help groups and peer education can provide emotional support to deal with the additional complexities related to TB, including stigma and discrimination. They can also support treatment literacy and adherence, and advocate for those facing barriers to service access. Detailed guidance on developing advocacy can be found in the WHO, UNAIDS, HIT and INPUD *TB advocacy guide for people who use drugs*.

3.11.4 TB treatment in prisons

Continuity of TB treatment in prisons and other detention settings is essential to reduce mortality, the development of resistance or onward transmission. Treatment must follow the prisoner through all stages of detention, including pre-trial detention, during prison transfer and following release.

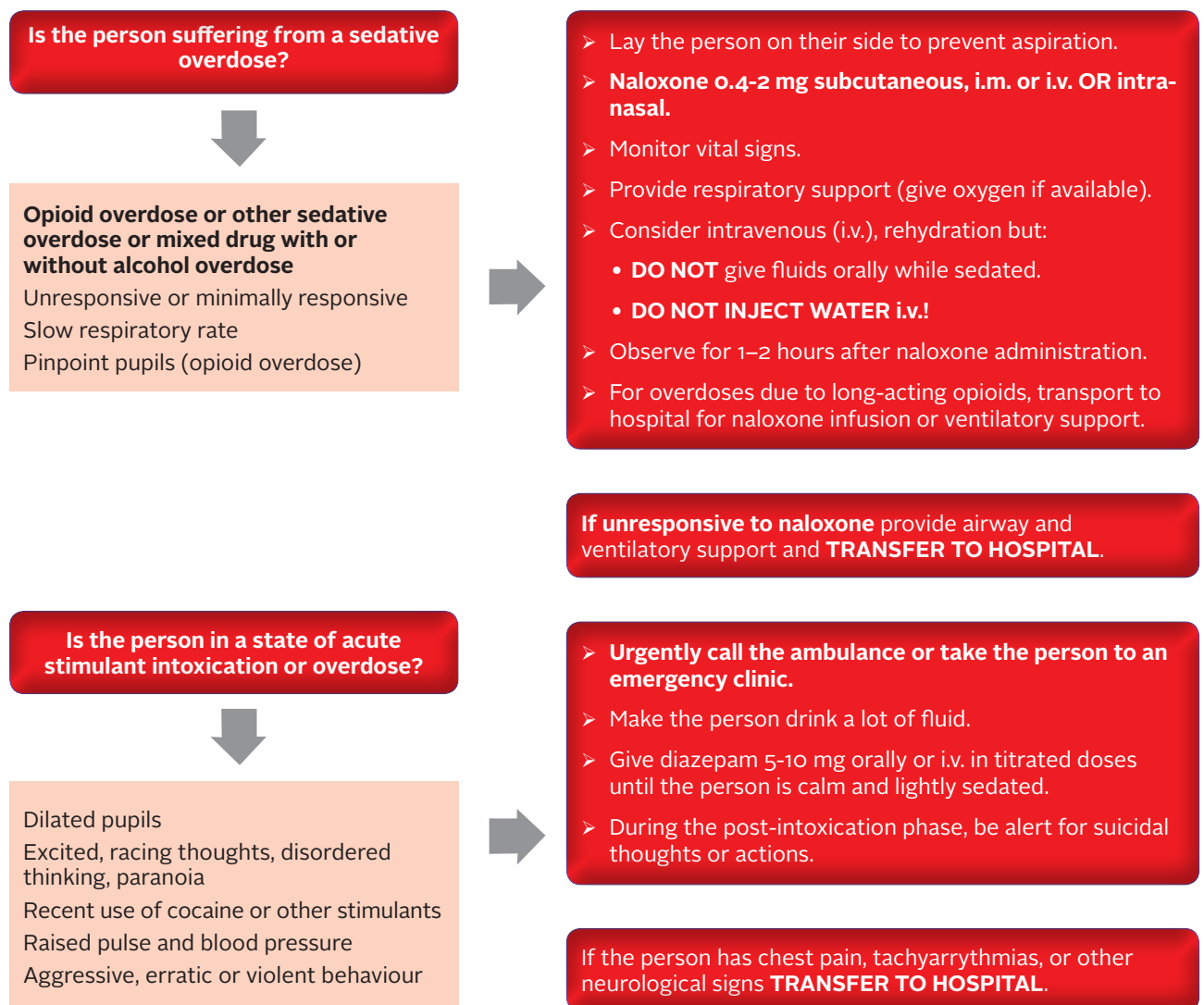
3.11.5 TB infection control

Places where people who inject drugs tend to congregate—e.g. safe spaces, drop-in centres, NSPs, drug-treatment centres, health facilities, shelters, sex-work venues and prisons—can expose them to increased risk of TB and MDR-TB if adequate TB infection control measures are not in place. These include early identification and respectful separation of individuals with TB symptoms, adequate ventilation, respiratory hygiene and health education, alongside rapid diagnosis and prompt start of TB treatment. People who work in such facilities who live with HIV or use drugs are also at increased risk of TB and should have access to TB prevention measures and be given the option to transfer to other sites that put them at less risk. It is crucial that client confidentiality is respected to reduce double stigma and discrimination arising from using drugs and also having TB.

3.12 Overdose prevention and management

Drug overdose is the leading cause of preventable drug-related deaths globally. In 2012 the UN General Assembly ratified a resolution of the Committee on Narcotic Drugs recommending that overdose prevention and treatment be included in every country's drug strategy.

Figure 3.2 Assessment and management guide for overdose emergencies



Adapted from: WHO. *mhGAP intervention guide–version 2.0* (2016)

3.12.1 Prevention

Several strategies for preventing opioid overdose exist. These include:

- expansion of related harm reduction interventions, such as the establishment of safe injecting centres and expansion of access to OST, which has been shown to reduce the risk of overdose
- education about the causes of opioid overdose and practical strategies for minimizing overdose risk

- training for responding to an overdose, including education on recognizing its symptoms, administering naloxone, and first aid and naloxone
- provision and administration of naloxone to manage overdose
- strengthening community monitoring of the purity and quality of drugs.

See also the WHO guidance on *Community management of opioid overdose* (2014).

3.12.2 Interventions to expand access to naloxone

Naloxone should be available in conjunction with—not as a substitute for—comprehensive overdose prevention and management training in community settings. Based on the experience of harm reduction organizations, efforts to increase access to naloxone should focus on:

- **Training and providing naloxone directly to nonmedical people (lay people):** This includes people at risk of an opioid overdose; friends and families of people who inject drugs; and peer outreach workers and others who might be present at an overdose.
- **Ensuring professional responders are equipped with naloxone:** This includes not just hospital, clinic and ambulance workers, but also emergency service workers/first responders such as law-enforcement and firefighters.
- **Expanding access through commercial points of sale:** This includes encouraging physicians to prescribe naloxone and making the drug available over the counter in pharmacies without a prescription.

Table 3.2 presents the features of the different approaches to distribution and their advantages and disadvantages.

Table 3.2 Approaches to naloxone provision

TYPE OF INTERVENTION	DESCRIPTION	ADVANTAGES	DISADVANTAGES
Provision to professional responders	All first responders have access to and training in the administration of naloxone, e.g. ambulance, police, firefighters	First responders are often the first trained professionals on the scene of an overdose	Some first responders (e.g. law-enforcement officers) may be unwelcome
Expanding points of sale	Work to expand nonprescription access to naloxone through pharmacies and other points of distribution	Increases access to naloxone	Lack of persons trained in administration
Direct distribution	Harm reduction programme distributes naloxone and provides training to clients through existing NSP, drug treatment, prison or other services, as well as to peer outreach workers, family and friends of people who inject drugs	Targets those most likely to witness overdose Ease of integration	Relatively large quantities of overdose response kits/naloxone are needed Political sensitivities may cause challenges to this approach

3.12.3 Steps to implement a naloxone distribution programme

1. **Raise awareness in the community:** Where available, collect existing overdose data. Conduct stakeholder meetings with those familiar with the local overdose context, including drug-user organizations, medical- and social-service providers and, if applicable, law-enforcement personnel.

2. **Determine policy constraints, scope, and focus of the intervention:** Because naloxone is a prescription medication in most countries, there may be a need for regulatory or legislative changes, or “trial” or other exemptions, in order for bystanders to administer naloxone.
3. **Select the formulation of naloxone for distribution:** While intranasal administration is preferable for laypersons (easy to administer and there are no needles) intramuscular injection may be the most readily available. Intramuscular is preferable to intravenous for laypersons as it is easier to administer, and the duration of action is longer. The minimum dose should be 0.4–0.8 mg on the first dose. Further doses may be necessary.
4. **Train trainers:** Once the scope of the intervention is determined, the trainers should be chosen. They may be people who inject drugs, medical staff, or social-service providers.

Box 3.16**Case example: Peer-led naloxone provision in China**

A harm reduction NGO in China distributed overdose hotline cards through an existing needle exchange. Bystanders witnessing overdoses contacted motorcycle-driving peer educators who administered naloxone. Six NGO peer workers successfully reversed 76 overdoses within 30 months with minimal extra programme costs. After gaining support from a local hospital, the programme began to distribute naloxone directly to clients and their family members. Community naloxone programmes are now operating in the provinces of Guangxi, Hubei, Sichuan, Xinjiang and Yunnan.

3.13 Psychosocial services

HIV care and harm reduction settings can provide an opportunity for the detection and management of mental-health issues among people who inject drugs. Studies suggest that mental-health problems in people living with HIV may interfere with treatment initiation and adherence and may lead to poor treatment outcomes. These issues can include depression and becoming suicidal, a range of anxiety-related issues as well as more severe mental illness, including affective disorders and psychosis, personality disorders and post-traumatic stress.

It is important that providers be aware of internalized stigma—the self-acceptance of the prejudicial views or stereotypes of others—which can lead to social withdrawal, a poor sense of self-worth and a subsequent reluctance to accept or adhere to treatment or other health and social services, as some individuals come to view themselves as undeserving of respectful treatment, or even of any treatment at all.

The WHO *mhGAP intervention guide–version 2.0* (2016) makes recommendations related to general mental-health care that can be relevant to people living with HIV, including those from key populations.

3.14 Further resources

NSP

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<http://www.who.int/hiv/pub/idu/needleprogram/en>
2. Strike C, et al. Needle exchange programmes: best practice recommendations. Toronto (ON): Ontario Needle Exchange Coordinating Committee; 2006.
<http://www.catie.ca/en/resources/ontario-needle-exchange-programs-best-practice-recommendations>
3. Burrows D. Starting and managing needle and syringe programs: a guide for Central and Eastern Europe/Newly Independent States. New York (NY): International Harm Reduction Development/ Open Society Institutes; 2000.
https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=oahUKEWjBhP7bkoPQAhXJK8AKHbvsDnkQFggeMAA&url=http%3A%2F%2Fharmreduction.org%2Fwp-content%2Fuploads%2F2012%2F01%2FStarting-and-managing-NSP-programs.pdf&usg=AFQjCNEB9Gm3oo_GgG5HErN58iKNBzBJSQ&sig2=mCr4MbamCY4NICowNTufsw

OST and other evidence-based drug-dependence services

4. Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence. Geneva: World Health Organization; 2009.
http://www.who.int/substance_abuse/publications/opioid_dependence_guidelines.pdf
5. Interventions to address HIV in prisons: HIV care, treatment and support. Evidence for action technical paper. Geneva: World Health Organization; 2007.
<http://www.who.int/hiv/pub/idu/idupolicybriefs/en>
6. Principles of drug dependence treatment. Vienna: United Nations Office on Drugs and Crime; 2009.
https://www.unodc.org/docs/treatment/Principles_of_Drug_Dependence_Treatment_and_Care.pdf
7. mhGAP intervention guide for mental, neurological and substance use disorders in nonspecialized health settings–version 2.0. Geneva: World Health Organization; 2016.
http://www.who.int/mental_health/mhgap/mhGAP_intervention_guide_02/en
8. Technical briefs on amphetamine-type stimulants (ATS). Manila: World Health Organization Regional Office for the Western Pacific.
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9. WHO/UNODC/UNAIDS position paper: substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention. Geneva: World Health Organization, United Nations Office on Drugs and Crime, Joint United Nations Programme on HIV/AIDS; 2004.
<http://www.unodc.org/documents/hiv-aids/Position%20Paper%20sub.%20maint.%20therapy.pdf>
10. UNODC Drug Dependence Treatment: Treatnet Training Package. Vienna: United Nations Office on Drugs and Crime; 2008.
<https://www.unodc.org/treatment/en/training-package.html>

HTS

11. Service delivery approaches to HIV testing and counselling (HTC): a strategic policy framework. Geneva: World Health Organization; 2012.
http://apps.who.int/iris/bitstream/10665/75206/1/9789241593877_eng.pdf
12. Delivering HIV test results and messages for re-testing and counselling in adults. Geneva: World Health Organization; 2010.
http://www.who.int/hiv/pub/vct/hiv_re_testing/en
13. Guidelines on HIV self-testing and partner notification. Geneva: Joint United Nations Programme on HIV/AIDS; 2016.
<http://www.who.int/hiv/pub/vct/hiv-self-testing-guidelines/en>
14. Consolidated guidelines on HIV testing services. Geneva: World Health Organization; 2015.
<http://www.who.int/hiv/pub/guidelines/hiv-testing-services/en>

ART

15. Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Second edition. Geneva: World Health Organization; 2016.
<http://www.who.int/hiv/pub/arv/arv-2016/en>

Sexual and reproductive health

16. Guidelines for identification and management of substance use and substance use disorders in pregnancy. Geneva: World Health Organization; 2014.
http://www.who.int/substance_abuse/publications/pregnancy_guidelines/en
17. Responding to intimate partner violence and sexual violence against women. WHO clinical and policy guidelines. Geneva: World Health Organization; 2013.
<http://www.who.int/reproductivehealth/publications/violence/9789241548595/en>
18. Implementing comprehensive HIV/STI programmes with sex workers: practical approaches from collaborative interventions. [The SWIT]. Geneva: World Health Organization; 2013.
<http://www.unfpa.org/publications/implementing-comprehensive-hivsti-programmes-sex-workers-practical-approaches>

Condom programming

19. Condom programming for HIV prevention: a manual for service providers. Geneva: World Health Organization; 2005.
<http://www.unfpa.org/publications/condom-programming-hiv-prevention>
20. Comprehensive condom programming: a guide for resource mobilization and country programming. New York (NY): United Nations Population Fund; 2011.
<http://www.unfpa.org/publications/comprehensive-condom-programming>

Viral hepatitis B and C

21. Guidance on prevention of viral hepatitis B and C among people who inject drugs. Geneva, World Health Organization; 2012.
<http://www.who.int/hiv/pub/guidelines/hepatitis/en>

22. Guidelines for the screening, care and treatment of persons with chronic hepatitis C infection– updated version April 2016. Geneva: World Health Organization; 2016.
<http://www.who.int/hepatitis/publications/hepatitis-c-guidelines-2016/en>
23. Guidelines for the prevention, care and treatment of persons with chronic hepatitis B infection. Geneva: World Health Organization; 2015.
<http://who.int/hiv/pub/hepatitis/hepatitis-b-guidelines/en>

TB

24. WHO policy on collaborative TB/HIV activities: guidelines for national programmes and other stakeholders. Geneva: World Health Organization; 2012.
http://www.who.int/tb/publications/2012/tb_hiv_policy_9789241503006/en/
25. Integrating collaborative TB and HIV services within a comprehensive package of care for people who inject drugs: consolidated guidelines. Geneva: World Health Organization; 2016.
http://www.who.int/tb/publications/integrating-collaborative-tb-and-hiv_services_for_pwid/en
26. TB advocacy guide for people who use drugs. Geneva: Joint United Nations Programme on HIV/AIDS, World Health Organization, HIT, International Network of People Who Use Drugs.
http://www.stoptb.org/wg/tb_hiv/assets/documents/TBHIV_Advocacy_Guide.pdf

Overdose

27. Opioid overdose: preventing and reducing opioid overdose mortality. Vienna: United Nations Office on Drugs and Crime; 2013.
<https://www.unodc.org/treatment/en/discussion-paper.html>
28. Community management of opioid overdose. Geneva: World Health Organization; 2014.
http://www.who.int/substance_abuse/publications/management_opioid_overdose/en/
29. Stopping overdose: peer-based distribution of naloxone. New York (NY): Open Society Foundations; 2011.
<http://www.opensocietyfoundations.org/publications/stopping-overdose>
30. Overdose prevention. [website.] Harm Reduction Coalition. Accessed 2016 December 5.
<http://harmreduction.org/issues/overdose-prevention>
31. Naloxoneinfo.org [website.] Open Society Foundations. Accessed 2016 December 5.
<http://www.naloxoneinfo.org>

Women and young people

32. Women who inject drugs and HIV: addressing their specific needs. Vienna: United Nations Office on Drugs and Crime; 2014.
http://www.unodc.org/documents/hiv-aids/publications/WOMEN_POLICY_BRIEF2014.pdf
33. Addressing the specific needs of women who inject drugs: practical guide for service providers on gender-responsive HIV services. Vienna: United Nations Office on Drugs and Crime; 2016.
https://www.unodc.org/unodc/en/hiv-aids/new/publications_drugs.html
34. Responding to intimate partner violence and sexual violence against women. Geneva: World Health Organization; 2013.
<http://www.who.int/reproductivehealth/publications/violence/9789241548595/en>

35. HIV and young people who inject drugs: a technical brief. Geneva: Joint United Nations Programme on HIV/AIDS; 2015.
<http://www.who.int/hiv/pub/toolkits/hiv-young-idu/en>

Prisons

36. Interventions to address HIV in prisons: effectiveness of interventions to address HIV in prisons. Evidence for action technical paper. Geneva: World Health Organization; 2007.
http://www.who.int/hiv/pub/idu/prisons_effective/en
37. A handbook for starting and managing needle and syringe programmes in prisons and other closed settings. Vienna: United Nations Office on Drugs and Crime; 2014.
http://www.unodc.org/documents/hiv-aids/publications/Prisons_and_other_closed_settings/ADV_COPY_NSP_PRISON_AUG_2014.pdf
38. HIV and AIDS in places of detention: a toolkit for policy makers, programme managers, prison managers and prison health staff. Vienna: United Nations Office on Drugs and Crime; 2008.
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39. Women and HIV in prison settings. Vienna: United Nations Office on Drugs and Crime; 2008.
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http://www.who.int/hiv/pub/prev_care/en/evidenceforactioncommunityfinal.pdf
42. Management of common health problems of drug users: guidelines for the primary health care of drug users. Delhi: World Health Organisation South East Asian Regional Office; 2009.
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4

Service Delivery Approaches



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What's in this chapter?

This chapter offers practical advice on designing acceptable and accessible services for people who inject drugs, and on involving community members as programme staff. It also describes in detail two particular aspects of community-led services: peer-led outreach, and drop-in centres.

4.1 Introduction

This chapter describes strategies for designing and implementing effective services for people who inject drugs. The principles of community empowerment¹ are particularly important: involving people who inject drugs in the design, planning, implementation and monitoring of services can have a positive impact on service uptake. The successful operation of community-led harm reduction programmes is constrained by the current environment of criminalization of drug use, stigma and discrimination. Harm reduction programmes have therefore been operated by nongovernmental organizations (NGOs) and community-based organizations that in a few countries are supported and funded by governments. This chapter discusses some general principles of working with people who inject drugs as staff members, which will be of particular use where harm reduction services are provided by organizations that are not community-led.

People who inject drugs can take on many roles within a harm reduction programme, including in education, advocacy, clinical services, administration, programme management, monitoring and oversight. The chapter focuses on two specific categories: peer outreach workers, i.e. people who inject drugs who are trained to deliver or support access to harm reduction services, and peer navigators, who help people to navigate social services, legal bureaucracies, and health services for treatment and care for HIV and other conditions. Finally, the use of drop-in centres as delivery points for services is discussed.

4.2 Strategies for designing and starting effective services

- **Planning and assessment:** A careful assessment of the situation prior to starting services will improve the programme's effectiveness and sustainability. The World Health Organization (WHO) *Rapid assessment and response guide on injecting drug use* (1998) provides tools that help in this process. Lack of data should not hold back development of services, but it is important to initiate and strengthen research and data collection to develop the evidence base and inform programming.
- **Community mobilization:** Effective programmes engage people who inject drugs in decision-making from the earliest stages: in assessments, planning and decisions about sites, types of commodities and services to be provided. (For services in prisons, see the publication by the United Nations Office on Drugs and Crime and the European Monitoring Centre for Drugs and Drug Addiction, *HIV in prisons: situation and needs assessment toolkit* (2010).
- **Community-led services:** Meaningful involvement of the community can be enhanced by engaging and training community members to promote, coordinate, deliver and monitor services, including outreach, running drop-in centres, navigating primary health care and other services, and for overdose prevention and treatment. For more details, see Section 4.3.
- **Staff training:** It is crucial to provide continual training for health-care workers and other staff who interact with people who inject drugs to improve their technical and communication skills.

1 In most contexts in this tool, "community" refers to populations of people who inject drugs rather than the broader geographic, social or cultural groupings of which they may be a part. Thus, "outreach to the community" means outreach to people who inject drugs, "community-led interventions" are interventions led by people who inject drugs or people with community connectedness, and "community members" are people who inject drugs or people with community connectedness. For a closer definition, see Chapter 1, Box 1.1.

- **Flexibility:** Programmes must be flexible and be reorganized when necessary to stay effective in quickly changing local drug-using situations.
- **Monitoring:** Monitoring and evaluation (M&E) is crucial to assess whether the intended objectives of the programme are being accomplished, as well as to understand and respond to the changing needs of clients (see Section 4.2.4). People who inject drugs should play an important role in the M&E of programmes by giving feedback on the effectiveness, quality and acceptability of services.

Box 4.1

Client-focused services

Services that are carefully designed to meet the needs of people who inject drugs will be more effective. Equally important is a human-rights based approach. The United Nations Committee on Economic, Social and Cultural Rights (General Comment 14) recognizes that the right to health is fulfilled only if essential services are nondiscriminatory, scientifically sound, gender-sensitive, culturally appropriate, noncoercive, humane and respectful. The following characteristics apply to all services described in this chapter. Services should be:

- **Appropriate:** Effective, high-quality, and provided in a timely manner and addressing the needs of people who inject drugs. Health services should be in line with international standards, current best practices and guidelines.
- **Accessible:** Offered at times and places convenient for people who inject drugs, including outside normal working hours and at weekends. Where possible, services should be integrated (co-located) or closely linked so that a broader range of health services can be accessed in a single visit (see Section 4.2.2). Cross-training of providers is important. Services should be low-threshold, available without appointment and with short waiting times.
- **Acceptable:** Health-service providers should be discreet and respectful, nonjudgemental and nonstigmatizing. They should be trained in duty of care and understand how to address the particular needs of people who inject drugs. Services for people who inject drugs are best delivered in community-based settings and with close collaboration with civil-society organizations and government (or national) health services and authorities. Peer navigators should be available where requested, to assist clients' access to services and their understanding of proposed interventions (see Section 4.5.4). Programmes should take into account that women who inject drugs are often more marginalized and have extremely limited access to harm reduction services. The varying needs of young people and older people who inject drugs must also be considered when designing services.
- **Confidential:** There must be trust between clients and service-providers. Counselling and examinations should take place in private rooms. Confidentiality of personal information must be guaranteed according to medical standards. Whether the registration system is electronic or paper-based, access to it should be strictly limited and traceable. Client information must never be given to nonmedical third parties without the client's agreement.
- **Nondiscriminatory:** All clients should be treated fairly regardless of age, sex, sexual orientation, gender identity, ethnicity, religion, class, occupation and drug use status. There should be a clearly displayed "charter of service" for clients. In particular, there should be

no legal impediments or barriers to young people accessing harm reduction services or to service-providers delivering such services to young people.

- **Informed consent:** Services must be voluntary. All clients must give consent for treatment, based on sufficient and accurate information to make an informed choice. The right of any client, including people who inject drugs, to refuse treatment must always be respected.
- **Affordable:** Services should be free or affordable, bearing in mind the cost of transport and lost income opportunities for people visiting a service-provider. Where possible, programmes should be easily accessible by public transport so that regular attendance is feasible.
- **Safe:** Programmes must have policies to support client safety, particularly in settings where drug use is criminalized.

4.2.1 Considerations for providing services to specific groups

Reaching specific groups of people who inject drugs, such as women, young people, lesbian, gay, bisexual or transgender people, or sex workers can be challenging, and consideration should be given to how to make services flexible and accessible to these groups. Wherever possible, it is advisable to recruit drug-injecting individuals from these groups to reach out to their peers, and adapt the services to meet their expressed needs.

All staff should be trained on the differences between the ways in which specific groups procure, use and respond to different drugs. Training should be provided by representatives from all specific groups who inject drugs and health specialists. Evidence-based information can ensure that services are appropriate and incorporate the community's knowledge and experience.

Harm reduction interventions, including needle and syringe programmes (NSPs) and opioid substitution therapy (OST), and like treatment for HIV, tuberculosis (TB) and hepatitis, should be available without interruption within all parts of the criminal justice system. Prisoners enrolled in NSP or OST prior to imprisonment should be able to continue these programmes while on remand, in prison and after being released. A seamless continuum of care requires close collaboration between prison health services, police and court services, health-care providers and community-led organizations. Liaison with community services provides an important point of connection for people leaving prison that can support prompt engagement with health-care services and treatment adherence. Bringing community services into prisons can reduce the risk of disengagement from health-care services upon release and strengthen the care pathway. See also Chapter 2, Section 2.3.5.

4.2.2 Service delivery models

People who inject drugs can have multiple health, economic and psychosocial needs which pose significant challenges to service-providers. Detention, chronic unemployment, homelessness, stigma and discrimination have severe negative impacts on their experience and uptake of health care, including treatment adherence. Systems of service delivery must be based on a solid understanding of these complexities and provide an enabling environment for treatment success. The quality and effectiveness of service provision should be defined by the client and monitored by the service-provider and the government.

Box 4.2

Case example: Providing services to women who inject drugs in Ukraine

The Women for Women (W4W) initiative was developed to provide gender-sensitive HIV and harm reduction services, especially for women who inject drugs, female partners of people who inject drugs and female ex-prisoners. The programme, initially piloted with the support of UNODC, was handed over to municipal services in Ukraine in November 2013.

Six existing harm reduction NGOs were awarded grants to incorporate gender sensitivity into their services, including support for interventions of particular importance to women such as prevention of gender-based violence (including counselling for male sexual partners), legal assistance, child care, hygiene and food supplies, shelter, self-esteem skills-building and job placement. Links were also established with local government clinics and social services. Training for the NGO staff as well as some government representatives included a study tour to Vienna to familiarize participants with the day-to-day running of HIV and harm reduction services for women, and workshops on how to develop these services. Participants also received capacity-building in outreach techniques, leadership and empowerment, advocacy and fundraising. Women who inject drugs are involved in many aspects of service delivery.

Over the project period (2011–2013), just over 2,000 women received services through the programme. Involving municipal service-providers in harm reduction services for vulnerable women in their own communities has helped to reduce stigmatization and discrimination. The challenge of financial sustainability is addressed by incorporating programme activities in local service-delivery structures. Intensive training ensures that NGO and government providers have the advocacy, management and fundraising skills needed for long-term sustainability of the services. Equally important has been maintaining a dialogue between the civil-society organizations and local administrative structures.

Although separate sections of this chapter address distinct health services, the goal of effective programme planning should be to create closely linked or integrated service-delivery models with the fewest barriers for people to access services. High-quality services are ideally based where people who inject drugs live or congregate, so that they are easy to access and use. Various models can be considered, depending on the available infrastructure, as shown in Table 4.1. Some services may be delivered from a fixed site, usually a drop-in centre (see Section 4.6) or clinic. Some services may be wholly outreach-based, i.e. delivered either from a mobile unit or by peer outreach workers² visiting people in the community. Ideally, programmes should combine both fixed-site and outreach models.

² A peer outreach worker is a person who injects drugs who conducts outreach to other people who inject drugs, and who is not generally full-time staff of an HIV prevention intervention (full-time staff might be called “staff outreach workers” or simply “outreach workers”). Peer outreach workers may also be known by other terms, such as “peer educators” or “community outreach workers”. However, the terms “peer” or “community” should not be understood or used to imply that they are less qualified or less capable than staff outreach workers.

Table 4.1 Models and locations of primary clinical care for people who inject drugs

DELIVERY LOCATION	BENEFITS	CHALLENGES
Drop-in centre	• Comprehensive services may be provided; mix of clinical interventions and prevention and information is possible • Flexible to address needs of men and women who inject drugs • Involvement of people who inject drugs is possible	• May not have clinical services • Quality of service provision can vary • Can be difficult to form formal links with mainstream health services
Mobile outreach Van or bus, or on foot	• May reach hard-to-reach people who inject drugs • Acceptable and accessible • Cost-effective if accessing significant numbers of hard-to-reach people who inject drugs • Flexible response where there is a hostile environment for fixed sites	• Hours of service delivery and range of services provided may be more limited than at a drop-in centre
Clinic Government, NGO, or private	• Better clinical services • Quality assurance standards are monitored • Linked directly to other mainstream health services	• Stigma and discrimination may be an issue • Limited hours of access

The services provided to people who inject drugs, and the means by which they are delivered, will depend on a variety of factors, including the legal status of drug use and of harm reduction services and materials. As harm reduction becomes more widely accepted, it is important that services be made available not just in urban areas but in rural ones or small communities where drug use is common. In such settings, formal committees of people who inject drugs may not be established, but a village committee may work to ensure that people who inject drugs in their villages have access to sterile needles and syringes, for example via pharmacies or shops.

Organizations planning programmes should take into account that law-enforcement practices in specific localities may not reflect what is prescribed in national law. This presents an opportunity for engagement with law enforcement at certain sites. Where possible, and if safe to do so, organizations can work with law enforcement by initiating dialogue and negotiating agreements to prevent the harassment of community members at service sites. (See Chapter 2, Boxes 2.11 and 2.12 for further information.) Further factors to be considered are the local types and patterns of drug use, the level of empowerment of the community, and the human and financial resources available for implementation activities.

Case management

Case management is an effective model for maintaining long-term compliance with health care for people who inject drugs, particularly when receiving services at a health-care facility (rather than a community-based one). Case management is based on the following approach:

- **Initial on-site interview** as part of disease screening and diagnosis
- **Intensive case management** phase to support clients through challenges when entering the health-care system. Here, the case manager and client address issues such as:

- transport problems (financial and logistical)
- the optimal time for the client to attend clinical services
- fears or negative prior experience with medical staff
- scheduling all upcoming exams and clinical check-ups.

During this phase the case manager has regular meetings with the client, accompanies them to the health-care clinic, introduces them to staff and adjusts the schedule for future visits.

- **Maintenance phase:** the case manager makes regular calls to the client and checks with health-care personnel about any problems. During this phase it is recommended to invite the client to prevention and treatment literacy sessions, to ensure that they fully understand the purpose of medical procedures and future steps, i.e. antiretroviral therapy (ART). Case management during the maintenance phase addresses broader issues of health, social and psychological well-being, including clinical decisions regarding takeaway doses of methadone, and addressing the support needs of the client's family, especially the health and well-being of any children.

Service integration

Integrated services provide the opportunity for client-centred prevention, diagnosis, treatment and care for the multitude of issues adversely affecting people who inject drugs. This “one-stop shop” approach can include any of the comprehensive package of harm reduction services. The key factor in effective integration is not only co-location of services, but also collaboration between service-providers, e.g. to enable ARV dispensing and condom and lubricant distribution at OST clinics. Where integrated service provision is not possible, it is important to establish and maintain strong links among health services working with people who inject drugs. This can be facilitated through interagency cross-training, staff secondment and by strengthening quality across referral networks.

4.2.3 Making harm reduction programmes acceptable to the local community

The stigma that attaches to people who inject drugs affects where services can be located, including fixed-site NSPs and OST clinics. In some cities and municipalities, laws and ordinances stipulate that a drug-treatment clinic may not be located close to schools, churches, playgrounds and similar public spaces. Local authorities and politicians respond to the real or perceived concerns of the wider community and often fail to support the establishment of harm reduction services in the places where they are needed. As a result, there are often too few clinics, and ones that are set up may be difficult to reach, with limited public transport options. This increases the daily hardship for people who inject drugs and reduces access to and uptake of services, including treatment.

Careful and ongoing advocacy is needed in the local wider community to prepare for the establishment of any service for people who inject drugs, and in particular for low-threshold services such as NSP or OST. Implementation and delivery of essential services may be hampered not only by laws but by negative (and frequently inaccurate) media coverage. Frequent harm reduction trainings for media and police personnel, timely meetings with law enforcement and sensitization programmes for members of the wider community and policy-makers may help to create a more supportive environment for programmes. In addition, programme managers and service-providers can work with people who inject drugs to address concerns presented by members of the wider community. In many cases, behaviours that raise objections are easily addressed by people who inject drugs themselves; for example, peer outreach workers may collect used syringes from locales frequented by members of the wider community, or may persuade people who inject drugs not to do so in locations such as children's playgrounds. For more information, see Section 4.6.2.

4.2.4 Monitoring and evaluation

Several frameworks exist for monitoring the response to HIV among people who inject drugs:

- **WHO, UNAIDS, UNODC technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users–2012 revision.** Geneva: World Health Organization; 2013.
- **Tool to set and monitor targets for HIV prevention, diagnosis, treatment and care for key populations.** Geneva: World Health Organization; 2015.
- **Consolidated strategic information guidelines for HIV in the health sector.** Geneva: World Health Organization; 2015.
- **Operational guidelines for monitoring and evaluation of HIV programmes for people who inject drugs.** Geneva: Joint United Nations Programme on HIV/AIDS; 2011.

Each of these frameworks recommends a set of national-level indicators. These indicators assess key factors related to the enabling environment; measure the availability, coverage and quality of specific interventions; and examine their outcome and impact.

4.3 Planning community-led harm reduction services

Community-led harm reduction services are interventions designed and delivered by people who inject drugs to help others in their community access the health care and support they need, especially for HIV and hepatitis C (HCV) prevention. It is an approach that worldwide has been under-employed and would benefit from scale-up. If a harm reduction programme is not run by a community-led organization, employing staff who are people who inject drugs, or former injecting drug users who maintain community connectedness (i.e. who continue to maintain association, shared values and understandings with others who inject drugs), will make it easier to connect and establish relationships with other people who inject drugs in their location.

People who inject drugs can create an enabling environment that encourages other people who inject drugs to access health care and social support, even where the national policy and legislative framework is hostile, or injecting drug use is criminalized or discriminated against. With sustained support, community-led harm reduction services can also provide the basis for a strong advocacy movement that challenges structural barriers and the stigma and discrimination that underpin many institutional responses. Whenever possible, therefore, community members should be recruited to the programme team. These should be current or former people who inject drugs who live in the service area and know it well, and who also know and are respected and trusted by their peers. The steps outlined in Chapter 1 to build trust and rapport with the community should be followed.

In some contexts, community-led harm reduction programming may not be feasible, either because there is no organized community of people who inject drugs, or because punitive laws and practices make it unsafe for people who inject drugs to provide visible outreach. In these cases, an NGO may organize initial outreach. If the programme team consists primarily of noncommunity members, they should ideally be people with local knowledge who are connected to and trusted by people who inject drugs. Where feasible, the implementing organization should establish a steering committee of community members to help monitor and oversee the outreach work done by noncommunity members (see also Section 4.4.3).

Box 4.3

Case example: Comprehensive outreach in Indonesia

PEKA, a civil-society organization based in Indonesia's West Java province, provides a continuum of care for people who inject drugs in Jakarta, and the cities and districts of Bogor. The majority of workers also have experience using drugs. PEKA offers an education programme on life skills, HIV prevention and care, and addressing stigma. The peer outreach programme distributes sterile injecting equipment and offers referrals for HIV counselling and testing, antiretroviral treatment and other medical consultations, and referrals for general health as well as for HIV. A peer support group disseminates up-to-date information on HIV and drug use. The programme also offers counselling and paralegal assistance to advocate for the legal and other needs of clients in detention. All the services provided are documented and managed under the programme division of PEKA Halfway House.

Box 4.4

Fundamentals for community-led harm reduction services

While there are various approaches and models for delivering community-led harm reduction services, certain organizational practices will help ensure that the services effectively address the needs of people who inject drugs within their own context and community:

- The organization has a values statement supportive of people who inject drugs, and developed with their close participation.
- People who inject drugs hold decision-making positions in the management structure.
- The policies of the organization take into consideration staff who inject drugs and protect their safety and their human rights.
- The organizational strategy is responsive and adaptable to accommodate needs and changes in the community.
- An independent body, composed of community members (e.g. drug user unions), is set up to deal with concerns from the community.
- There is good documentation of both the lived experience of people who inject drugs and the services that have a positive impact on their lives, to ensure that learning can be shared and built upon.

4.4 Recruiting and managing community staff in programmes

4.4.1 Recruiting community members

In the initial stages of a programme, selecting community staff (including, but not limited to, peer outreach workers) may be an informal process: the implementing organization may invite people who inject drugs to become involved in the programme as peer outreach workers or in other capacities, and to help identify and recruit others. As the programme grows, it is likely that more

people who inject drugs will come to know of it and may want to be involved. An optimal process for recruiting and training community staff can be developed over time, and the following steps should be considered:

- Form a steering committee comprising community members, the funding body, members of the wider community and other stakeholders.
- The steering committee drafts a Terms of Reference for staff positions, outlining the selection and recruitment criteria as well as the roles and responsibilities and reporting lines of the staff. This includes policies on salaries and allowances as well as career progression opportunities.
- Develop a strategy to disseminate the Terms of Reference so that the greatest possible number of people who inject drugs know about the opportunity to be part of the programme as staff and have time to apply.
- Develop or choose a training curriculum: many are now available for a range of settings, especially for peer outreach workers, so one can be chosen that best fits the environment and available resources. (See also the examples of training topics for peer outreach workers later in this chapter.)
- Articulate the options for staff to develop their role within the organization over time and to take on greater responsibilities for outreach, programme management or other services and activities.

4.4.2 Managing and supporting community members

In certain settings, community members joining a harm reduction programme as staff may have little or no prior work experience. The programme must commit to working patiently with them and making allowances that might not be given to noncommunity staff (e.g. regarding punctuality, frequency of breaks). Organizations should not replicate prohibitive antidrug strategies such as urine analysis or threats of dismissal for using drugs. Flexibility for delivery should be built in and should reflect the often-changing environments in which staff who inject drugs live. This means accepting that their health, legal or family commitments may have to take precedence over their work at times.

Nevertheless, there should be clear communication between pre-existing programme staff (both community and noncommunity) and community members who work for the programme, covering expectations for their work and for interactions with programme staff and clients. All staff need a clear line management structure and job descriptions that explicitly state the boundaries of their role and the tasks for which they are responsible.

Working in the harm reduction field can be stressful in and of itself, and “burnout” is an occupational hazard. This is damaging not only to the staff but to the programme as well, since valuable experience and knowledge may be lost if a staff member leaves. It is therefore crucial to ensure that staff have access to and take advantage of regular supervision to enable them to process some of their experiences, learn from them where possible, and receive support and assurance that they are not working in isolation. Supervision should be compulsory and weekly, and should address not just the functions of the job but also its impact upon the worker, including how to maintain good boundaries. Some organizations offer training on any relevant topic requested by staff and pay them for attending training sessions.

The fair and equal remuneration of staff who are community members is essential and should be considered from the beginning of the programme planning process. Even if there is a lack of formal qualifications, community members possess crucial and practical knowledge based on lived experience. These contributions, over time, can mean that community members often become the backbone of an organization as peer outreach workers, as well as in other positions.

4.4.3 Independent oversight

In addition to the programme steering committee, it is important to create an independent body comprised of community members to oversee the management of the programme, advise on policy and act as arbitrator in the event of disputes or complaints from service users. This ensures that community interests remain paramount.

Box 4.5

Case example: Community-led monitoring of access to health and rights in Pakistan

From 2013 to 2015 the Association of People Living with HIV in Pakistan (APLHIV), in partnership with Mainline, a Netherlands-based organization, established a network of people who inject drugs in Pakistan, and a tool with which this network could monitor their community's access to health and rights and the quality of services.

APLHIV and Mainline first led a community assessment of access to health facilities, harm reduction services and rights for people who use drugs in Pakistan. Based on the assessment, the Drug User Network Pakistan (DUNE) was established under the umbrella of APLHIV and equipped with a project officer. With APLHIV support, DUNE developed a tool for community-led monitoring, and members of the network were trained to use it. The tool contains questions for service-providers and service beneficiaries on health services and rights issues.

Once the tool had been reviewed by Mainline and finalized, Nai Zindagi, the Global Fund's Principal Recipient organization for HIV projects in Pakistan, agreed to have its services monitored. Community members implemented the questionnaire, taking care to ensure regional coverage, representation of females, and age diversity. After the questionnaires were completed, a technical consultant helped analyse the data, and DUNE reported the results to Nai Zindagi, which responded and discussed how it could improve its projects to better serve people who inject drugs.

www.theaphiv.org.pk/index.php/our-networks/dune

4.5 Peer-led outreach

4.5.1 How peer outreach workers promote access to services

Employing and training members of the community, i.e. people who inject drugs, can be the most effective way for a programme to reach people who inject drugs, because:

- They have a personal investment in providing services to other members of the drug-using community.

- They often live in communities, or visit locations, that are inaccessible to outsiders, including workers from traditional service-providing organizations.
- They have firsthand knowledge of how to inject drugs safely, and are familiar with drug trends and changing patterns of use.
- They are more likely to be trusted by the community to give appropriate, high-quality referrals to services, being consumers of those services themselves.
- By instilling trust, they increase the likelihood that people who inject drugs will follow up on referrals, adhere to treatments and engage in health-seeking and health-protective behaviours.
- People who inject drugs are likely to be more comfortable discussing personal details of their lives with someone who has similar experience.
- The common experience may help decrease internalized stigma and increase self-worth and collective solidarity.
- They are well placed to provide support to the family and friends of people who inject drugs, if requested to do so.

A person who injects drugs may move in and out of injecting or using other drugs, either by their own choice or in response to life events or treatment programmes. Peer outreach workers can act as a mentor and catalyst for positive change, by helping persons who inject drugs to identify elements of their lives that they want to change, putting them in contact with available relevant services, and supporting their decisions. They can also help them evaluate the impact of such decisions as changes occur. Peer outreach workers may also be able to help mitigate the damage from life events caused by circumstances outside the control of the person who injects drugs.

With appropriate training opportunities, peer outreach workers can become powerful advocates, by articulating changes needed in services, and in society as a whole, and by challenging the stereotypes often held by the wider community that people who inject drugs are unreliable, dishonest or victims of circumstance.

4.5.2 Recruiting and training peer outreach workers

As with other positions occupied by community members, the selection criteria for peer outreach workers should be clearly articulated and written down. A peer outreach worker should be:

- someone who currently injects drugs, or a person who has previously injected drugs who maintains community connectedness³
- in places where harm reduction services for people who inject drugs are already established, a peer outreach worker should have been receiving services from the programme for people who inject drugs for at least six months
- committed to the goals and objectives of the programme
- knowledgeable about the local area
- accepted, respected and trusted by the community
- accountable to the community as well as the programme

³ In some contexts there can be challenges in employing former injecting drug users who do not maintain community connectedness. They may express a feeling of superiority towards current injecting drug users, and there may be a risk that former users become active users again, which could present an increased risk of overdose for them.

- able to maintain confidentiality
- good at listening and communicating, and nonjudgemental
- tolerant and respectful of others and of diverse communities of people who inject drugs, where these exist
- self-confident, with leadership potential
- potentially a strong role model for the behaviour they want to promote
- willing to learn and experiment in the field
- committed to being with other people who inject drugs through crises that may occur
- potentially able to negotiate with police and government officials, when needed.

Box 4.6

Services commonly offered by peer outreach workers

- Deliver harm reduction commodities to ensure safer injection and use, as well as helping to safely dispose of used equipment (see Chapter 3, Section 3.2 for details).
- Provide condoms and lubricants, along with information on safer sex and sexual and reproductive health (SRH) and rights.
- Provide information on request on:
 - overdose prevention (including naloxone distribution), safe injection, wound management and other harm reduction principles
 - specific drugs, routes of administration and drug trends identified within the community and more generally
 - prevention, testing, care and support for HIV, hepatitis, other sexually-transmitted infections (STIs) and TB
 - options to manage drug use (including distributing prescriptions or take-home doses of methadone or buprenorphine, where possible, and other therapeutic alternatives)
 - legal aid, health care or social support services.
- Promote the services available at the drop-in centre, where this exists (see Section 4.6).
- Help to facilitate continuity of care for people who inject drugs who transition into or out of incarceration.
- Encourage people who inject drugs to articulate and demand services they need for themselves and for their families.
- Encourage people to test their drugs in order to identify adulterants or substituted chemicals/pharmaceuticals/drugs.
- Help in managing crises—whether personal, family or community.
- Providing differentiated information for the specific needs of women, men, young people and transgender persons or other groups with distinct needs.
- Accompany people who inject drugs to health clinics, courts or other official meetings for support, if requested (see Section 4.5.4).
- Deliver peer-provided HIV testing services, and case management services (see Chapter 3, Section 3.4.4).
- Help people who inject drugs living with HIV to acquire sustained access to ART (see Section 4.5.4).

Box 4.7

Case example: Peer-led outreach in Thailand

CHAMPION-IDU began in 2009 as a peer-led HIV prevention project that sought to improve the quality of life of people who inject drugs in Thailand. Around 80% of the 250 CHAMPION-IDU workers hired have been people who inject drugs (currently or formerly), giving them an opportunity for meaningful employment and building their capacity to become productive members of society.

Peer outreach workers operate via drop-in centres and mobile outreach, offering behaviour change communication to reduce risks, education about sterile injecting equipment, condoms, overdose prevention with naloxone, and referrals for HIV testing and counselling, methadone maintenance treatment, ART and diagnosis and treatment of STIs. Peer outreach workers are provided extensive support, especially in the context of frequent, negative law-enforcement encounters, to empower them, promote their professional development and safeguard their health and safety.

CHAMPION-IDU's strategy has been successful in engaging people who inject drugs and facilitating their access to health services because of the innate trust that exists between peers. Government drug-treatment centres have seen up to a fourfold increase in in-patient and out-patient admissions since the project began.

CHAMPION-IDU was implemented by the Global Fund until the end of 2014. Since 2015, it has continued in a scaled-down version called the STAR project, currently implemented by the Ozone Foundation, a locally registered peer-driven organization. For more information, see [CHAMPION-IDU: Innovations, best practices and lessons learned](#). Washington (DC): Population Services International; 2015.

Basic training should be given before peer outreach workers begin. Further specific training should then be offered regularly to enable peer outreach workers to develop their skills and learn new ones, as well as keep up to date with current thinking on the issues with which they are working (see Box 4.8). This may include acquiring formal qualifications that will equip them to work in other facilities or contexts if they wish.

Box 4.8

Training topics for peer outreach workers and staff

Basic training

- An overview of the programme
- Harm reduction
- Basic knowledge of drugs and drug-injecting equipment, safe injecting practices, local trends in drug use and novel psychoactive substances (NPS)
- Safe distribution and collection of injecting equipment, as well as sharps disposal
- Overdose prevention and treatment (including how to administer naloxone and how to identify stimulant and depressant overdoses)
- Prevention, diagnosis and treatment of HIV, HCV and TB
- Condom and lubricant distribution
- Health services and referral systems
- Gender issues, including differences in how males and females use drugs
- Developmental, welfare and special needs of young people who inject drugs
- Violence and crisis intervention, including de-escalation skills
- Identifying and addressing stigma and discrimination and recording human-rights violations
- Interpersonal communication skills
- Mapping, planning and monitoring outreach routes
- Data collection

Advanced training

- Leadership skills
- Community mobilization
- Providing counselling and support
- Challenging prejudice
- Legal literacy, negotiating with police
- Using the media to advantage
- Income generation skills, e.g. training to advise and set up loans and savings groups and income-generating activities
- M&E
- First aid
- Drug policies

4.5.3 Implementing outreach

Programmes should recognize peer outreach workers for the special expertise and experience they bring, also being sensitive towards and accommodating the challenges faced by people who inject drugs. Flexibility and support are key to the successful integration of people who inject drugs as peer outreach workers, both in terms of the outreach worker's work plan, and in terms of how the programme as a whole interacts with the outreach worker.

- **Working hours may be unconventional**, since it is often more convenient to meet and work with people who inject drugs in the evening or at night.

Box 4.9

Case example: Peer-led outreach in Pakistan

The Nai Zindagi Trust has been providing comprehensive and evidence-based services to street-based people who inject drugs, their families and sexual partners in selected districts of Pakistan for 25 years. The trust works in cooperation and collaboration with the public health-care system to avoid creating parallel services, and 60% of services are provided by Nai Zindagi partner organizations.

A core principle of Nai Zindagi's work is the involvement of people who inject drugs in programme design, implementation and evaluation: 30% to 40% of peer outreach workers and field supervisors are former injectors. The programme prioritizes outreach over facility-based service-delivery approaches. Harm reduction (including NSP but not OST), HIV and STI prevention, diagnosis, treatment, care and support services are offered, as well as a two-month residential ART adherence programme for people living with HIV. Access to skills training and employment for clients is also available.

Over 600 individuals have been trained to provide a range of comprehensive services since the inception of current programme activities (funded by the Global Fund) in 2012. Consistent and expanded outreach has supported services for approximately 13,000 street-based people who inject drugs. Inclusion of sexual partners and children has been a significant intervention for prevention of secondary infections. District AIDS Councils have been established in selected districts to reduce stigma, engage government and the public sector in order to facilitate access to health, social welfare and HIV-related services for Nai Zindagi clients. Nai Zindagi has shared experiences and technical information with programmes in Nepal, Indonesia and Kenya.

www.naizindagi.org

Source: Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations–2016 update. Geneva: World Health Organization; 2016.

- **Levels of contact with clients may vary:** Although each peer outreach worker may be assigned a specific set of individuals to contact on a monthly basis (usually in a specific area), the needs and circumstances of those individuals will play a significant role in determining the level of contact. When life is fairly stable, a service-user may only want to see the staff for resources such as injecting equipment or condoms and lubricant. In times of crisis such as arrest or detention, or the illness or death of a partner or family member, the service-user may seek out the peer outreach worker and need more time and attention.
- **Regular supervision is essential,** particularly when peer outreach workers are beginning their work, so that they do not feel overwhelmed by the responsibility of working within programme parameters that are still new to them. Starting a peer outreach worker off with a few hours a week and gradually building their time may be an effective approach.
- **Listen to the peer outreach worker** when they advise of changes in the number of contacts or commodities supplied. Reasons for increases may include greater use of drugs by clients at weekends or at holidays or around payday; reasons for decreases may include clients going into treatment, or being incarcerated. These changes are important to document in order to share learning and inform programming decisions.

- **For administration and record-keeping, meet the peer outreach worker where they are:** be clear about the importance of tracking data that the programme needs, and offer repeated training as needed. Find ways to simplify forms to make them as easy as possible to use, or offer to have an outreach supervisor help the peer outreach worker complete forms until they are used to doing so themselves.
- **Allow for time off** because of sickness, medical or legal appointments. Be considerate with breaks (e.g. smoking breaks) during meetings and trainings. If a peer outreach worker is arrested or incarcerated, offer support—and reassure them that their position will be open to them upon their release, if they wish to continue.
- **Ensure that support is available to help peer outreach workers deal with stress, burnout and grief,** and that these support structures are incorporated into human-resources policies. As frontline workers, peer outreach workers may have to deal with very difficult situations with their clients as well as in their own lives. Proper support will enable them to remain engaged in their work.

Confidentiality

Privacy and confidentiality are essential when working with people who inject drugs, as with other criminalized and stigmatized communities. The risk is that their status as drug users will be exposed to law enforcement or the wider community when accessing services.

Respect for privacy, confidentiality and the principle of “do no harm” must guide the programming cycle. Maintaining these principles and values is not only crucial for the protection of people who inject drugs, but has positive implications for the programme. People who inject drugs are much more likely to enrol in and continue to access services where they know that their rights to safety and confidentiality are respected.

All staff must be trained to ensure that confidential consultations are not held in places where they can be overheard, and to not speak openly about the HIV status, drug-use status and personal life of community members. During the delivery of HIV prevention services, outreach workers must be careful not to draw attention to people who inject drugs or to drug use.

Managing information in such a way as to protect confidentiality is essential. Any written documentation regarding the identity and location of people who inject drugs must be kept confidential and in a secure location. If there is any possibility that it could be confiscated by authorities and used to arrest or harass people who inject drugs, it should be coded in a way that keeps key information about them safe from such misuse. One approach is to have a unique identifier code (UIC) or an alias for each client, so that there is a clear and easy way to record and follow up the interaction with that person, but at the same time, the identity, location or residence of the client cannot be determined by information contained in the file.

Using ID

It is helpful to have identification cards made for peer outreach workers and endorsed by a senior public-health official (or law-enforcement official, where possible) that they can carry while working, to help them confirm their positions if stopped by the police or when advocating on behalf of a client for services.

Safety

The safety and well-being of service-users and staff should always come first. The arrest, harassment or even kidnapping of people involved in outreach, especially needle and syringe distribution, is not unknown. Outreach workers should always carry at least one phone and leave a record of their approximate schedule or itinerary so that the programme knows where they plan to go. Programmes should consider sending outreach workers out in pairs, particularly in hostile or dangerous environments.

4.5.4 Peer navigation

Staff who use drugs can be ideal navigators to help their peers deal with health, social-service and legal systems that are often discriminatory, stigmatizing or simply confusing. Many people who inject drugs have negative experiences of these systems, and their distrust often leads them to avoid seeking services.

Trained peer navigators—peer outreach workers or other community members with experience of these systems—can encourage other people who inject drugs to access the services they need and can support them by accompanying them when requested (Box 4.10). Similarly, if a person who injects drugs tests positive for HIV, a peer navigator living with HIV can be particularly effective in linking them to ART services, answering their questions and encouraging them to adhere to treatment.

4.6 Drop-in centres

Where possible, a drop-in centre to access harm reduction and basic support services should be created in the location where people who inject drugs live. Such centres should always be hosted by staff members who inject drugs who are already known to the community.

4.6.1 Planning a drop-in centre

Consulting with community members is important to help decide where to locate a drop-in centre, the services to be provided, staffing and service hours. Services should be available when people who use drugs most need them. The choice of location should take into consideration not only its accessibility but also its visibility to the public. Care should be taken to ensure that the centre is safe from intrusion by outsiders and the police.

Before opening a drop-in centre, it is important to engage with the neighbours and the wider community, to explain the centre's purpose, the operational plan and to address any questions or concerns. Unless they have experience living with or working with people who inject drugs, local residents may be anxious and prone to prejudice and stereotyping about people who inject drugs. Often service-providers face opposition because of fears over increased crime, improper needle and syringe disposal, and public-order disturbances.

Programme managers can prevent and deal with opposition through sustained advocacy and through health promotion and education efforts within the general community. This involves coordinating and cooperating with local law-enforcement and government officials, health- and social-service providers, community leaders, and other members of the wider community. Patience, careful planning and the ability to show that the facility will be properly run and managed are essential at this stage.

Box 4.10

Case example: Peer navigation in Canada

The COUNTERfit programme in Toronto observed that people who inject drugs were most likely to seek services from a doctor, nurse or social worker if they had established a positive, trusting relationship with them. However, it was observed that service users were reluctant to keep appointments with housing workers, lawyers, parole officers and specialist doctors because they frequently experienced disrespect, discrimination and violation of their confidentiality. COUNTERfit found that even at its own clinic, service users who were accompanied by drug-using staff members received better care than those who went to their initial appointments alone.

These observations led COUNTERfit to offer accompaniment by peer navigators to service users who needed to attend court proceedings, parole hearings, bail reviews, HIV or HCV testing (or receiving test results), social work appointments, landlords and tenant boards, and specialist physician appointments. Peer navigation offers several advantages:

- Many service users forget their appointments, often because they are not regularly employed and have a problem maintaining a schedule. Peer navigators remind the service user of their appointment and go to their home in good time in case they have forgotten or are asleep.
- Service users have already established relationships with the peer navigators, who are community members who understand discrimination and the effects of stigmatization. The service user trusts completely that the peer navigator is on their side and will do their best to get the best service available for the client.
- Service-providers treat service users much more professionally when they are accompanied by a peer navigator—both outside and within COUNTERfit's services.
- Peer navigation is a cost-efficient and effective way of disease prevention for people who inject drugs. COUNTERfit's peer navigators are paid \$15.75 Canadian dollars per hour, which is very little compared with the savings gained by keeping a person who injects drugs healthy and reducing the likelihood of their being admitted to an emergency room or sent to prison.

A challenge to making peer navigation work is the length of some appointments, especially court cases or specialist medical appointments, where there may be long delays or waiting times. This can increase costs for the peer navigation service, although delays can sometimes be mitigated with some advance preparation (e.g. calling a court clerk or doctor's secretary to explain and ask for an expedited appointment). Some peer navigation work can be stressful for the navigator, who is contending with stigma and discrimination directed both at the client and at themselves. It is important that programmes offer proper support (e.g. debriefing) and financial compensation. It is also very important to have back-up navigators available in case the peer navigator is unable to make the appointment as planned.

People who inject drugs can play a crucial role in helping to show neighbours that they are responsible and committed to maintaining the security and stability of the community and that this facility will benefit all. In some instances, hostility and suspicion may not abate until after the centre has opened and the feared disadvantages fail to materialize. Continuous and open communication is needed to avoid confrontational situations.

Plans to address potential opposition to a drop-in centre should be integrated into the programme design and planning stages. A first step would be to map and identify potential allies, with the aim of reaching out and engaging them to build relationships of trust, communication and cooperation. Sensitization workshops and discussions can take place on the needs and rights of people who inject drugs to health and social support services. Running public information campaigns is also useful in improving the knowledge and changing the attitudes of the wider community. Finally, being able to provide and share locally generated evidence of the success and efficacy of the programme is a key factor to its ongoing success. The time invested in building and fostering community relations improves the acceptability of the programme and creates a strong enabling environment.

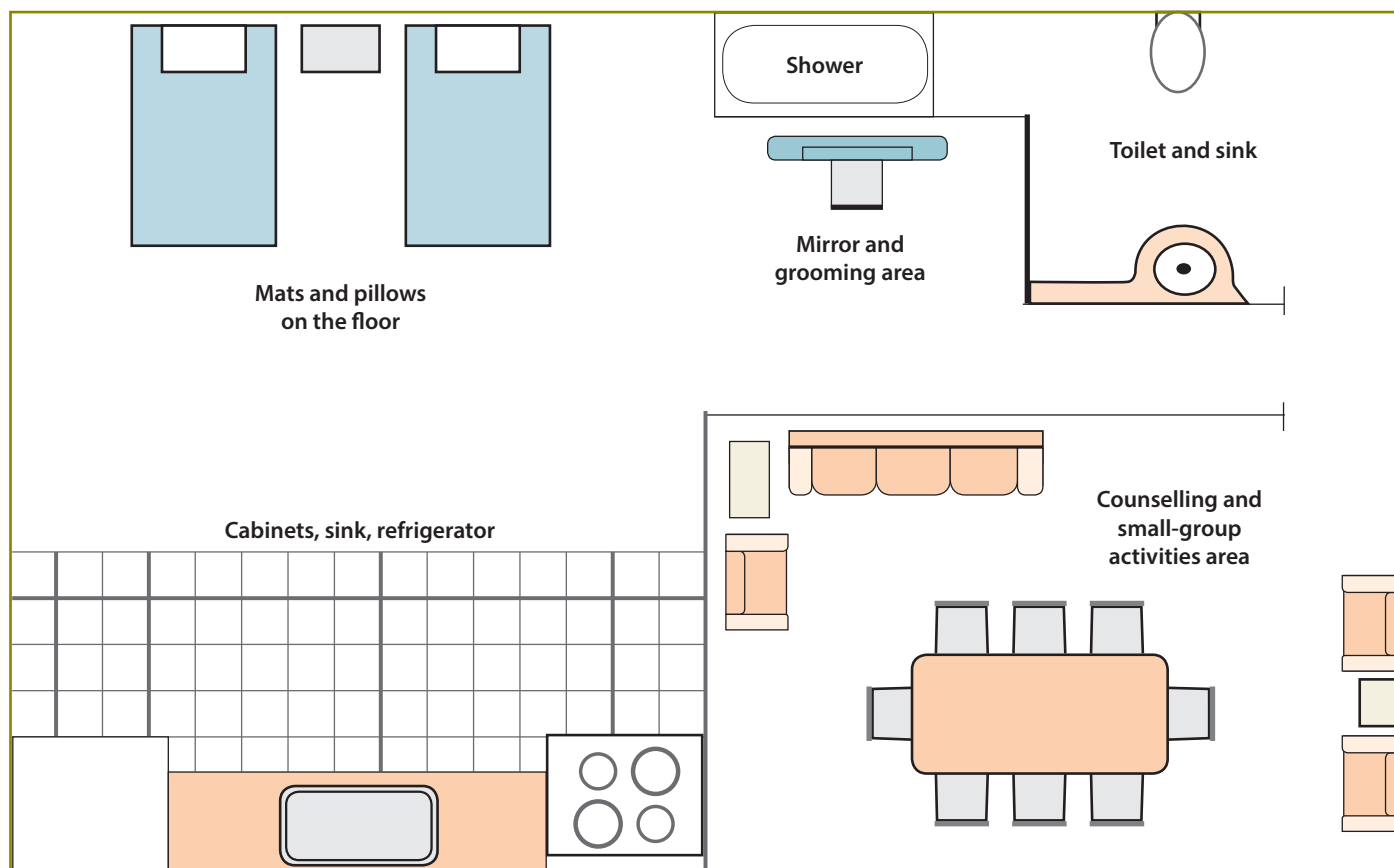
4.6.2 Setting up the centre

Lease agreements and landlords: Maintaining a fixed location for the drop-in centre is important to prevent disruption of services. The lease drawn up with the landlord should clearly state the duration of the agreement and clarify the hours and nature of use.

Infrastructure and safety: The drop-in centre should ideally have at least two rooms: one that can be used for one-on-one meetings or counselling, and one for community activities. If possible, there should be a private bathroom with a sink and shower. The centre should be equipped with basic equipment to handle fires and other emergencies. Since it is likely to have numerous visitors in close proximity to one another, measures should be taken to reduce the risk of transmission of TB through adequate ventilation and awareness of symptoms (see Chapter 3, Section 3.11).

Designing the space: The drop-in centre should be both functional and inviting. Meeting tables and chairs may be kept to one side unless in use; couches or mattresses can make the room comfortable. Walls may be decorated by community members.

Figure 4.1 Example of a drop-in centre floor plan



4.6.3 Providing services

Harm reduction services that can be offered in a drop-in centre include:

- harm reduction resources and commodities, especially sterile needles and syringes
- primary health care (abscess/wound management, other health issues)
- peer education
- user-friendly information, education and communication materials
- information on safer injecting and safer sex
- condoms and lubricant
- drug analysis
- counselling and referral to other services
- OST
- counselling and testing for HIV, hepatitis, STIs, TB—or referrals for these services if they are not available at the drop-in centre
- safer consumption facilities.

Where possible, qualified staff might provide:

- mental-health services
- housing or shelter services

- emotional support with family crises
- alternatives for well-being and healthier lifestyles
- legal advice, both criminal and civil
- support in getting papers in order after release from prison
- overdose support.

Box 4.11

Providing services for the whole person

A drop-in centre provides the programme with the opportunity to offer services that address the wider physical and social needs of its clients, beyond harm reduction. This is important because these needs often go unaddressed when people who inject drugs suffer stigmatization and isolation. The following support services can be considered:

Food: People who inject drugs who face housing insecurity and lack social support are often undernourished, and this can seriously exacerbate any health conditions they may have. Where possible, food should be made available and offered free of charge or at a nominal cost. Some people who inject drugs like to volunteer to work in the kitchen, either to alleviate boredom, or to have company or physical warmth. This should be encouraged to create a sense of ownership in the centre.

Laundry facilities

Showers/baths where homeless people who inject drugs can maintain personal hygiene

Comfortable seating area where people can meet, talk and relax in a safe environment

Sleeping space: If homeless or ill, people who inject drugs frequently have nowhere to safely rest. Where possible, a place with camp-beds for short naps or longer periods of sleep should be made available.

Computer/Internet facilities

Crèche facilities or play area for the children of people who inject drugs

Careful consideration should be given as to how the drop-in centre can be used by the wide diversity of people who might require a service. The possibility of opening the centre exclusively for particular groups at some points during the week should be considered, such as:

- women
- young people
- migrants and ethnic minorities (who may need language support)
- lesbian, gay, bisexual and transgender people
- sex workers.

Box 4.12

Case example: Providing services to women via a drop-in centre in Tanzania

In 2010, when Médecins du Monde opened the first drop-in centre for people who use drugs in Tanzania, most of the attendees were male drug users. Staff recognized that women who inject drugs had different needs and access barriers than men, and identified additional interventions to enhance access to harm reduction for women.

A weekly “women only” evening commenced for women who inject drugs to access services in a woman-focused environment. Services include gender-based violence support and STI and sexual health care services by a gynaecologist. There is a women's room and bathroom at the centre. Various commodities are provided in addition to new injecting equipment and condoms. Women can participate in peer education activity. A women's outreach service has also been established.

The women's night is well attended, with an increasing uptake of HIV testing, sexual and reproductive health, referrals to prevention of mother-to-child transmission and other harm reduction services. Women use the space to share ideas concerning drug use, health, pregnancy, child care, gender issues and family issues. For some, the service has been an entry point to become peer outreach workers. Women report that ancillary services (e.g. showers, provision of hygiene materials, nutritional support, hair, make-up and washing facilities) are crucial and improve their access to health services and NSP. A self-support group is engaged in income-generating activities.

The benefits of a gender-sensitive service model relevant to women who inject drugs have drawn the attention of stakeholders interested in expanding the model to other harm reduction services in Tanzania.

4.6.4 Operating the centre

Management: The programme should provide resources for the drop-in centre. To ensure that the community feels ownership, people who use drugs should have the lead role in decisions about the centre and its management.

Service promotion: To ensure people who use drugs are aware of the drop-in centre and its services, it should be promoted through flyers, text messages and community networking.

House rules: These should be formulated by those using the centre so that they understand what behaviour is acceptable, e.g. with regard to noise levels.

Relationships with neighbours: The managers, including the community, should make plans to manage relationships with neighbours and those outside the community. Some communities have performed neighbourhood clean-ups to establish a good relationship with their neighbours.

Scheduling: If the programme needs to use the drop-in centre for programme activities that involve a limited number of participants (e.g. outreach planning, training, or interpersonal and group communication activities), these should be scheduled during off-peak hours so that they do not infringe upon access for the broader community.

Programme use: Growing implementing organizations may want to use the drop-in centre for other programme activities. However, efforts should be made to ensure that this does not happen or that such activities are kept to a minimum. The centre should remain open to members of the community.

Sustainability: Drop-in centres can be made financially sustainable when managed by the community. For example, the community might rent out space to the programme on a limited basis, or develop catering services for events at drop-in centres as a form of income generation.

Box 4.13

Case example: A community-led drop-in centre in the USA

The San Francisco Drug Users Union runs a drop-in centre offering low-threshold services for drug users, provided by drug users. The centre operates in the Tenderloin District, the lowest-income neighbourhood in the city and the one with the highest concentration of people who inject drugs.

The drop-in centre offers services including needle distribution (in conjunction with the state department of public health), naloxone for overdose, rapid testing for HIV and HCV, wound care, and education. It also provides bathroom access and Internet access, both important amenities for people who inject drugs, many of whom live on the streets. It is the largest fixed-site NSP in San Francisco, serving over 350 people each week and exchanging an average of 30,000 syringes monthly. Volunteers and staff are all people who use drugs. Some do street outreach, and a volunteer crew cleans up discarded injection equipment in the neighbourhood. This service has helped build and maintain support for the centre in the wider local community. The drop-in centre is a base for activism too, such as organizing marches for drug-users' rights. Because the community in San Francisco is quite transient, there is some turnover of staff and volunteers, but this has not affected the centre's ability to provide consistent services. The centre is funded by the state, nonprofit donors and private donations. It is currently open five days a week but is seeking funding to open on additional days.

www.sfdrugusersunion.com

4.7 Further resources

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<http://www.cahrproject.org/resource/standard-operating-procedures-to-reduce-and-manage-relapse-and-burnout>
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<http://canadianharmreduction.com/node/2208>
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<http://www.catie.ca/en/resources/peerology-guide-and-people-who-use-drugs-how-get-involved>



5

Programme
Management



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What's in this chapter?

This chapter presents principles and approaches for programme management, divided according to a sequence of assessment, planning, implementation, and monitoring and evaluation. This sequence is appropriate for developing a programme from scratch, or where existing programmes are to be added to or scaled up.

5.1 Introduction

This chapter explains how to establish a management system for an HIV and hepatitis C (HCV) programme for people who inject drugs, serving multiple locations within a country, and multiple sites within urban locations. Such a programme will use various service-delivery approaches (see Chapter 4) to cover a high proportion of people who inject drugs with a minimum package of services.

Box 5.1

Principles for programme management

- Programme managers should always be focused on the programme's purpose—to optimize the health and well-being of people who inject drugs—and base decisions and approaches on it.
- Services for people who inject drugs should be comprehensive, evidence-informed and human-rights based and include a variety of types of service delivery, including peer-led outreach.
- As a general principle, all data collected for planning, for monitoring and for evaluation should be disaggregated by gender and age group.
- While it is ideal for programmes to be initiated and led by community members,¹ this will not always be possible. Nevertheless, governmental and nongovernmental organizations planning programmes for people who inject drugs must remember that it is crucial to involve community members in the design, implementation, monitoring and evaluation of programmes to ensure their success and sustainability. Regular and meaningful engagement with service recipients should be institutionalized, with mechanisms provided for input and feedback on a regular and as-needed basis.

Effective management systems enable managers and teams to:

- plan and administer the activities of multiple interventions at various levels within the programme
- define roles and responsibilities, provide oversight and manage relationships with external partners
- ensure all levels of the organization are trained appropriately with regular training updates, performance measures, and staff planning and development
- take into account the range of individuals involved, the networks and organizations within which they operate, and the social systems and structures that surround them
- coordinate the operational activities that support the work, including data reporting systems, commodity procurement, quality monitoring and improvement, support and supervision, training etc.

¹ In most contexts in this tool, “community” refers to populations of people who inject drugs, rather than the broader geographic, social or cultural groupings of which they may be a part. People may move into or out of injecting drug use at various times in their lives but may maintain community connectedness. Thus, “community members” are people who inject drugs or people with community connectedness, “outreach to the community” means outreach to people who inject drugs, and “community-led interventions” are interventions led by people who inject drugs or people with community connectedness. For a closer definition, see Chapter 1, Box 1.1.

- implement financial procedures and controls
- adopt best practices, i.e. policies, programmes and initiatives that are:
 - evidence-informed
 - human-rights based
 - sensitive to the subgroups of people who inject drugs (e.g. women, young people)²
 - sustainable
 - regularly evaluated
 - participatory, involving all partners, especially community members.

5.2 Assessment

5.2.1 Define the scope of the response—population size estimates and mapping

Key steps in starting a programme include knowing where to establish services and contracting with implementing organizations.³

- At the central planning level, reliable information about the size of the community of people who inject drugs within a given geographic area forms the basis for locating services, funding, setting performance targets, allocating programme resources and assessing coverage. Data disaggregated by age and gender are a critical component of effective planning and programming.
- At the implementation level, programmers can use mapping and size estimates to:
 - estimate the size of the community in a given area to determine personnel needs
 - identify locations of people who inject drugs for locating interventions
 - understand the demographics of the community (e.g. age, gender, ethnicity, family context, type of drugs used) to ensure that outreach and services are appropriately tailored to local settings and to individual and community needs
 - identify which services are needed and where
 - obtain information on risk behaviours, risk perceptions, barriers and structural issues to inform initial design of the intervention.

Engaging local people who inject drugs is particularly important when mapping community members and services because it helps ensure that the information collected is complete and not based on inaccurate or discriminatory assumptions. Knowledgeable members of the community can validate the information and help ensure that the programme provides acceptable and accessible services to the greatest possible number of community members.

Mapping should aim to gather information on the numbers of people who inject drugs, their age group and gender, locations and times where they congregate, and the types of drugs used. In addition, already existing services for harm reduction should be mapped to avoid duplication. Information can be gained through informal conversations with community members or through

2 Young people who use or inject drugs are those in the age range 10–24 years, in accordance with the Interagency Working Group on Key Populations *HIV and young people who inject drugs: a technical brief* (Geneva: World Health Organization; 2015).

3 An implementing organization is an organization delivering an intervention to people who inject drugs, with a client-centred approach. It may be a governmental, nongovernmental, community-based or community-led organization, and may work at a state, provincial, district or local level. Sometimes a nongovernmental organization provides services through subunits at multiple locations within an urban area, and in this case, each of those subunits may also be considered an implementing organization.

a series of discussions or workshops held in a safe environment, where community members can talk about their needs and priorities.

Mapping and size estimation is a multistage process, focusing on increasingly local levels to refine the information and make it more accurate. Mathematical size estimate exercises may be used to validate these programme estimates. The size estimates are updated periodically, and remapping may be done if social, political or economic forces lead to significant changes in the population of people who inject drugs.

First stage: “Where in the country are significant numbers of people who inject drugs?”

To determine where services should be established, a central-level planner must first understand where people who inject drugs are located. This information may be obtained by interviewing key informants, such as health-care providers and people who inject drugs who are already known to the programme. An approximate number of people who inject drugs should be obtained for each identified area in order to focus interventions initially on the locations with the largest number.

Second stage: “How many people who inject drugs are found in this municipality/area, and where? What is their risk and vulnerability, and what are their service needs and preferences?”

Once the general geographic area is known, more detailed mapping and size estimation may be done. This exercise can be an adaptation of the PLACE method (*Priorities for Local AIDS Control Efforts*) or a participatory site assessment, depending on the level of involvement of people who inject drugs in the mapping and size estimation process.

Participatory site assessments can be conducted with trained community members, researchers and local community organizations. These help establish initial population size estimates and map subgroups (e.g. young people, women, sex workers, men who have sex with men), as well as hot-spots where community members gather, and existing services for people who inject drugs. By ensuring the involvement of community members, the participatory mapping process can help increase their self-esteem, empowerment and identification with the programme and ensure that programmes are implemented with maximum safety in mind.

Locations identified by multiple informants or described as having large numbers of people who inject drugs are investigated further to ascertain whether these are people at high risk of HIV and HVC. Detailed information is sought from, discussed with and validated by people who inject drugs on the number of people who inject drugs in their social circle, specific places where people who inject drugs gather and any additional areas near the location where other people who inject drugs may be found.

The programme uses this information in close consultation with the community to decide where service points such as drop-in centres⁴ and clinics should be located. Other clinics may be listed and mapped to establish referral relationships. The programme design is further refined and informed

⁴ A drop-in centre is a place where people who inject drugs may gather to relax, meet other community members, and hold social events, meetings or training. See Chapter 4, Section 4.6, for details.

by people who inject drugs who describe the locations, hours, habits and other information that will determine when, where and how services are set up.

Third stage: “How can people who inject drugs be reached?”

In this stage, social network maps are typically used to identify precisely who may be reached by individual peer outreach workers⁵ and to further inform local planning, taking into account the values and preferences of people who inject drugs.

Box 5.2

Mapping and the confidentiality and safety of community members

Mapping should always be done discreetly and with the active involvement of the community of people who inject drugs. Maps and other data containing information about people who inject drugs (e.g. location) should be considered confidential and stored securely at a central location, such as a drop-in centre. Programme planners and implementing organizations should guard against the possibility of maps being obtained by law-enforcement authorities or other groups that might use them to locate sites or otherwise cause harm to people who inject drugs. If these confidential materials are disclosed, it is likely that the programme will lose the trust of the community.

It is important to note that lack of data cannot be an excuse for inaction. Interventions should be implemented while investing in the necessary research and data collection initiatives required to further develop the evidence base.

5.2.2 Develop national and local responses—needs assessment

A needs assessment provides the opportunity to focus on the specific needs of the communities of people who inject drugs nationally or in a more local area. It provides essential input to supplement information gathered during the process of population size estimation and mapping. For organizations already involved in harm reduction or HIV prevention programming, it can confirm—or revise—existing understandings of communities of people who inject drugs.

A needs assessment can help identify a new initiative or demonstrate the validity of existing programmes. It can also provide valuable evidence to create a persuasive argument for why a specific service or programme is needed, and support funding applications and discussions with donors and partners. It is important that as many stakeholders as possible be involved in a needs assessment: community members, including women and young people, their families, key service-providers, other civil-society partners, policy-makers, funders and donors.

⁵ A peer outreach worker is a person who injects drugs, or a person with community connectedness, who conducts outreach to other people who inject drugs, and who is not generally full-time staff of an HIV prevention intervention (full-time staff might be called “staff outreach workers” or simply “outreach workers”). Peer outreach workers may also be known by other terms, including “peer educators”, “community outreach workers” or “outreach workers”. However, the terms “peer” or “community” should not be understood or used to imply that they are less qualified or less capable than staff outreach workers.

Box 5.3

Four steps in conducting a needs assessment**Step 1: Perform a “gap” analysis**

A gap analysis identifies the gaps that exist in programming to prove there is a need for a further intervention. This can be done by conducting a written survey or interviews with key informants; running a consultation, focus group or meeting with them to identify gaps and discuss solutions; or, at the local level, giving a feedback form to current programme clients that can be completed anonymously.

Step 2: Identify priorities

The gap analysis will generate a list of ideas for potential new initiatives or ways to develop an existing programme. All organizations must prioritize and decide what they can and cannot provide or achieve. This means reviewing the list of gaps and deciding which ones are most important to the organization’s goals, capacities and constraints, and the needs of the community.

Step 3: Identify problems and opportunities

A needs assessment will also raise potential problems and opportunities. It is useful to think about how the organization can respond by listing data and ideas that fall into these two categories. This is a level of detail that donors and funders will be interested in; it shows that the organization is taking into account all the issues that may arise, both negative and positive, and how the organization will manage them.

Step 4: Identify possible solutions and planning

Using the information from Step 3, solutions and potential plans can be mapped to show how to manage each of the problems and opportunities identified.

5.2.3 Understand the environment

The community’s on-the-ground knowledge should be supplemented by research to gain a clear picture of factors that might affect the way services can be delivered and where service points may be located. These factors include:

- national and local laws and policies regarding drug use⁶ and harm reduction services
- the attitudes and behaviour of police and other law-enforcement authorities
- the attitudes of health- and social-services providers
- the attitudes and behaviour of the general community towards drug use, including people in neighbourhoods where service points (such as a drop-in centre or an opioid substitution therapy [OST] clinic) might be located
- attitudes of families of people using drugs, especially in communities where drug use is common
- the attitudes towards drug use of local politicians and local media
- the role of organized crime in drug provision (and whether a harm reduction programme might be seen as a threat to the business of selling drugs).

6 Drug use refers to the nonmedically sanctioned use of psychoactive drugs, including drugs that are illegal, controlled, or prescription.

Box 5.4

Consulting with the community

Outreach to the wider community, programme partners and service-providers is important for the security and protection of people who inject drugs and those who will provide services to them. The following steps will help ensure successful rollout of the programme:

- Consult with the community at large to explain the project and address possible concerns from the beginning.
- Consult with local police to explain the project and ensure the protection of people involved (service-providers and clients).
- Obtain authorizations from relevant authorities.

For more details, see Chapter 4, Section 4.6.2.

Local authorities can become allies following dialogue and negotiation to clarify the benefits they may see from harm reduction services (such as reduced expenditures on policing). Some of this information can be gathered through desk research, but most will require informal conversations with residents and local communities, partners and interested groups, and possibly more formal meetings with local authorities. In more open contexts, it may be possible to use established forums such as meetings of community councils to have a structured dialogue. Steps towards establishing productive relationships can include:

- Visit the relevant authorities during the programme-planning stage and identify a contact person within them for future communications.
- Develop joint multidisciplinary training sessions on working with people who inject drugs.
- Establish “rules” and agreements on how the outreach programme will work in conjunction with the higher-threshold services without breaching the trust or confidentiality of the drug-using community.

When working with these authorities, and especially with the police, who may be liable to harass and arrest people who inject drugs, every care must be taken to ensure confidentiality and protection for the community. This is a priority that cannot be compromised for any reason. For more information, see the *Practical guide for civil society HIV providers among people who use drugs: improving cooperation and interaction with law enforcement officials* (published by the United Nations Office on Drugs and Crime [UNODC], the International Network of People Who use Drugs [INPUD], and the Law Enforcement and HIV Network [LEAHN]).

Age barriers and underage drug use

While some countries may have restrictions and age barriers for accessing specific services, the programme's should aim to be as inclusive as possible and not to deny services to anyone who needs them, recognizing that children may start injecting well before the legal age of majority.

In some places parental consent is required in order to provide services, and this can prevent young people from getting tested for HIV. Again, programmes should strive to be as open as legally possible and to exercise flexibility to meet the needs of those seeking services. Service-providers should be enabled and formally approved to use discretion regarding managing younger clients.

5.2.4 Prioritize geographically

Financial resources are usually insufficient to cover all people who inject drugs in the entire country with the same package of services; as a result, programmes must prioritize both interventions and locations and match them according to local need, evident through the mapping and demographic analysis. This may be accomplished by varying the way in which technical components are delivered and by prioritizing those areas where the largest number of people who inject drugs and those at highest risk may be reached (see Section 5.2.2).

5.3 Planning

5.3.1 Develop the programme plan

The programme plan provides the direction for the programme. It can be developed at both a large-scale (e.g. national or state/provincial level) or at a smaller, simpler local scale (district or municipality level). Where local programmes are a part of a national programme, local plans will be coordinated with the national one. In general terms, the programme plan:

- gives clarity on the intervention elements and programme package
- establishes a logic model as a basis for monitoring the programme⁷
- makes it possible to assess programme quality.

The plan should be reviewed and revised as necessary over the life of the programme to reflect any changes in the population(s) being served or in the external political or funding environment. Components of the programme plan include:

Scope statement: Describes the need that the programme is aiming to meet and the rationale for the planned interventions. It outlines the parameters and restrictions (e.g. legal, funding) within which the programme will operate. It presents the interventions that will be delivered (i.e. the elements of the comprehensive package outlined in Chapter 3),⁸ the approaches that will be used, and measurable objectives and deliverables. The scope statement is a communications document that can be used to gain agreement with key governmental or sponsor organizations. The programme plan is closely linked to the **logic model**, which represents much of the same information in an abbreviated, graphic form and emphasizes the process of the programme (inputs, outputs and outcomes).

Baselines: These are initial measures of the elements that the programme intends to have an impact on, e.g. number of people who inject drugs, number of drop-in centres and attendees, number of needles and syringes distributed monthly, HIV or HCV infection rates etc. Progress of the programme is measured against these baselines indicators.

Task list: The task list includes a hierarchy of tasks for the whole life cycle of the programme (based on which tasks are dependent on other tasks being completed first), and a schedule that places all the tasks into a calendar. It identifies resources for each task, how long each task will take, how much it will cost and any constraints.

⁷ A logic model defines the programme's inputs, activities, outputs, outcome(s) and impact, plus associated indicators.

⁸ See also WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users–2012 revision.

Roles and responsibilities: It is important for the programme management to get clarity and agreement on what tasks and actions need to be done by whom, as well as which decisions and inputs each partner will make.

Reporting plan: This document specifies reporting processes, i.e. what reports are to be sent to whom, how often, when, in what format and using which media. It is important that the reporting plan specifies where programme information will be stored and who can access it.

Once the planning process is complete, its contents must be delivered to key partners. This communication should include:

- review and approval of the programme plan
- process for changing the contents of the programme
- next steps: executing and controlling the programme and key roles and responsibilities in the upcoming phases.

5.3.2 Establish management structures

A clear structure for implementation is essential for smooth programme management. This includes the roles and responsibilities at each level of implementation, both in the programme and outside (e.g. government, community, medical services, social services).

At the national/central level, the government or central management agency:

- sets programming standards
- monitors dashboard indicators⁹ from all implementing organizations in the country
- ensures that programmes are implemented in prioritized areas and subpopulations of people who inject drugs
- has a centralized view of the monitoring data
- ensures a countrywide evaluation plan.

If government or a designated central management agency is not setting standards or requiring centralized indicator reporting, implementing organizations should work together to implement the service package and centralize indicator collection in consultation with the government.

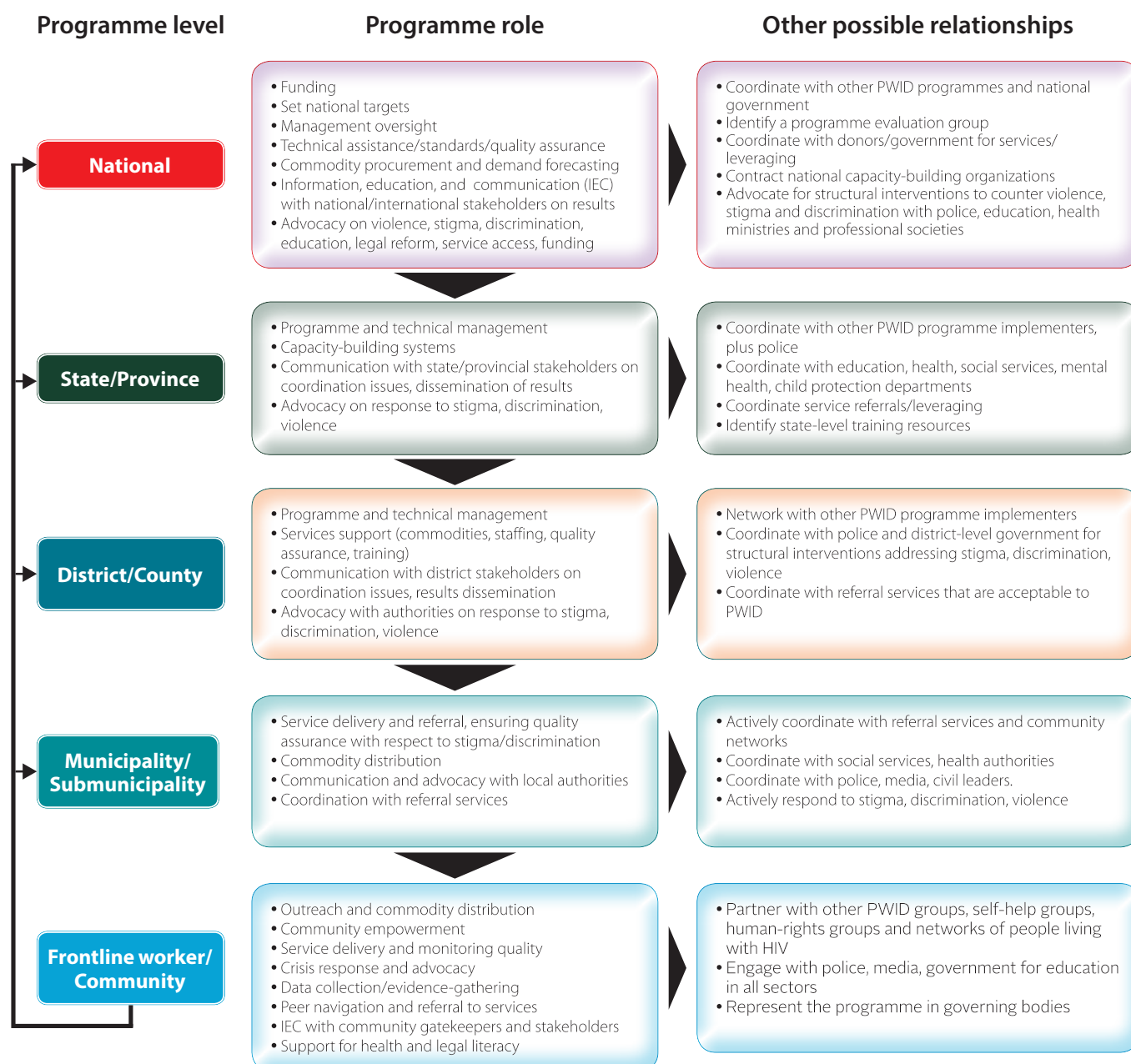
Figure 5.1 illustrates a management structure for a national programme, showing the oversight and reporting relationships with the programme as well as the external relationships managed at the various levels. Key management roles are:

- **setting milestones** coupled with field oversight for both quality and progress; it involves regular review of progress against targets to adjust strategies and tactics; and use of programme experience and data to make mid-course corrections as needed
- **establishing an organizational culture** that aims to:
 - empower people who inject drugs to manage the programme
 - empower staff at all levels to use local monitoring data to improve the programme
 - foster the professional development of all staff and promote cross-learning.

⁹ Dashboard indicators are the most important programme monitoring indicators, aggregated to a national level. They provide an overview of how well the programme is functioning (rather like the way gauges on the dashboard of a car inform the driver how well the engine is running).

Figure 5.1 Illustrative management structure for a national HIV prevention and care programme with people who inject drugs

Note: programme roles are not exhaustive.



5.4 Hiring and training staff

HIV programmes for people who inject drugs require team members with a variety of skills. The composition of a team depends on the services provided, how the services are delivered, the size of the community, and the geographic area being covered.

Several good practices have been articulated to ensure that staffing is optimal and that staff are motivated and satisfied by their work:

- clear job descriptions and roles and responsibilities for all positions in the programme, including positions held by community members
- clear reporting lines showing to whom each person is accountable
- team-building and a culture of mentoring
- clear criteria for performance reviews
- clear policies on leave, travel reimbursement and remuneration for work, including equitable policies for people who use drugs; ideally, these should be uniform across a country
- opportunities for training for different positions in the organization, such as outreach supervisor, clinic assistant, nurse, counsellor, social worker, office manager.

The relationships in a staff team that include both noncommunity staff (i.e. staff who do not use drugs) and community members need to be well managed. Noncommunity staff should be sensitive to the context of drug use, and to the stigma, discrimination, violence, and other problems people who use drugs face. They should also be able to discuss such topics as sex, drugs and service delivery needs in a nonjudgemental manner. A flexible approach and mindset amongst all staff members is crucial to respond to the needs and changing situation on the ground. Noncommunity staff should be prepared to learn from people who use drugs as well as serve as mentors.

Capacity-building of human resources is particularly important in programmes where the intent is to progressively empower people who use drugs to be meaningfully involved in programming. The capacity of noncommunity staff and community members can be built through classroom training, exposure, supervision and mentoring, and interactive problem-solving sessions. Training materials should be adapted or developed centrally to maintain quality of training and consistency with the minimum standards specified by the programme and be based on an assessment of the capacity-building needs. Pre- and post-assessments are useful to monitor the quality of the trainings.

Training goals for general staff include:

- acquainting the staff with the specifics of the project (e.g. intervention, reporting forms)
- building technical skills in new areas (e.g. examining for abscesses, counselling issues related to drug use)
- orienting staff to the issues of drug use and the important goal of imparting skills and responsibilities to the community. This may require a change in staff members' attitudes toward drug use (morality of drug use etc.).

Some approaches to capture programme lessons include:

- routine visits for programme managers to learn about local innovations and transfer lessons to other sites
- regularly scheduled programme reviews with several implementing organizations together; they may also be used for cross-sharing
- cross-site meetings of technical officers to share approaches
- formal revision of programme approaches, minimum standards, standard operating procedures and reporting forms.

For staff who are community members, the programme goal is to increasingly involve people who use drugs in the management of the programme and to capacitate them to address some of the

environmental and structural constraints that inhibit preventive behaviour. Training objectives are to strengthen the capacity of the people who use drugs to do peer outreach, increasingly manage all aspects of outreach and to move into other staff positions in the programme, including management. This can be phased as basic and advanced training.

Although staff may differ in their types and levels of experience, wherever possible training should take place jointly so that all participants can learn from one another and bridge the gaps in their knowledge and skills in a collaborative manner.

5.5 Programme implementation

Implementing and executing the programme in clear stages helps achieve wide geographic coverage (Figure 5.2). First, the programme is rolled out nearly simultaneously across the target geographic areas (as opposed to a pilot-and-replicate approach) by creating a physical infrastructure in these areas.

This is followed by a focus on implementing services and constant quality improvement. During implementation, the focus is on ensuring coverage of the community with services and on improving quality. The implementation phase is a continuous process in which management reviews progress against targets and adjusts strategies and tactics, as necessary. Mid-course corrections are made based on new data, new approaches or environmental or structural changes that affect programming. The intensity and the quality of coverage increases as staff become more skilled in their positions. It is during this phase that flexibility and continuous programme learning are extremely valuable. A strong monitoring system with regular reviews is essential to the successful rollout of services. It also signals to funders and the government whether programming is being implemented successfully.

Finally, as the interventions mature, the focus of implementation shifts to making interventions and services more sustainable. Additional services may be layered on over time.

5.6 Community-led quality improvement

Improving the quality, accessibility and acceptability of programme services requires collecting routine feedback on the community's experience of services. There are several ways to do this.

5.6.1 Community committees

A community committee is a forum for members of the community to bring important issues, problems and solutions to the attention of the programme on a routine basis. Committees may review clinical services, commodity distribution, and initiatives to address structural barriers. They can also be a communication channel for the programme to discuss any changes that are being considered and to share monitoring data with the community.

Community committees are comprised of people from the drug-using community, as well as from the wider community. They should meet monthly. Regular (e.g. annual) elections for committee representatives should be held. Staff from the relevant implementing organization may be invited to the meetings to discuss issues that arise.

Figure 5.2 Stages of implementing a multicomponent programme with people who inject drugs



Community committees operate primarily at the frontline level, although they may also contribute to the oversight of the programme at the municipality/submunicipality level. A meeting report like the one shown in Figure 5.3 may be used to systematically consider issues and report to the community and programme.

Figure 5.3 Sample community committee report

COMMUNITY COMMITTEE REPORT [LOCATION]		DATE:
Area	Issue	Proposed Resolution
Issues with supply, quality or quantity (e.g. needles and syringes, medications) at individual site or across sites	<i>Community reports that some peer workers who do outreach in the train station do not provide enough sterile needles.</i>	1. Outreach coordinator to work with peer outreach workers to provide the number of needles and syringes required by each community member. 2. Follow up at train station to ensure change.
Closure or lack of service availability at referral facilities or through outreach	<i>Government Clinic on Central Road often will not accept people after 15:00.</i>	1. Write letter to health officer documenting problem. Ask NGO director to sign along with community representative. 2. NGO health officer and community representative should visit Chief Medical Officer to advocate for compliance with agreement on later opening hours signed in May.
Service quality problems, e.g. poor treatment at facilities, discrimination in referral services, unresolved problems at safe spaces	<i>Nurses at Central Road doing initial questioning of patients in a public area, not a private room.</i>	1. NGO health officer and community representative should bring this up during visit with Chief Medical Officer to ensure compliance with STI treatment protocol. 2. Follow up with community to determine if clinic is compliant with policy.
Service overlap by other providers that may be causing confusion	<i>No problems.</i>	N/A
Violence response activities, perpetrators of violence and trends in violence.	<i>Report on number of incidents was not given at last community meeting at drop-in centre.</i> <i>Response team members taking survivors to hospital have not been reimbursed for transport costs.</i>	<i>Ensure that community leaders get information from crisis response team members and double-check it with NGO data officer before monthly community meetings.</i> <i>Outreach supervisor to check and ensure that reimbursements are made within one week.</i>
<i>Any other issues...</i>		

Actions taken by programme staff or peer outreach workers themselves, and the results, should be shared at subsequent meetings to ensure good communication with the community. A record of these discussions and actions should be maintained.

Because the community committee may at times raise quality issues that programme staff are reluctant to address, it is essential to involve programme management staff from a higher level than those immediately responsible for the components of the intervention locally. Confidentiality should be respected at all times, and senior management should monitor the committee to ensure that the community has the freedom to be critical. A trusted advocate should act as the programme intermediary; ideally this person should be a community member, although they may be

paired with a staff member from the implementing organization who can advocate for changes. A mechanism for communicating problems, beyond that of the local manager, should be established in case they are perceived to be obstacles to change.

Other community-led approaches to reinforce quality of clinical services

- Obtain agreement with referral clinics to display patients' rights charters, which are a statement of government policy for all who enter a medical facility.
- Obtain agreement with senior medical personal to post information in clinics on the right to confidentiality.
- Design ways to share information about reliable services in the community. This information may be posted on a notice board or on a protected Facebook page.
- Schedule regular contact (via visits or letters) with the chief medical officer of a facility to formally report issues and give positive feedback.
- Educate the community on patients' rights and community-based monitoring of services.
- Formally introduce committee members to health-service providers.

For ways in which community members can contribute to quality assurance in programme monitoring and evaluation, see Section 5.7.3.

5.7 Monitoring and evaluation

5.7.1 Monitoring

A routine data collection system is needed that aggregates and consolidates information so that dashboard indicators may be monitored. Monitoring data is used to:

- encourage ongoing improvement
- identify trends and emerging issues
- provide evidence of the impact of activities and outputs
- provide an informed basis for decision-making, review and future planning of services
- enable communities to shape service provision and engage in decision-making processes.

There are several data sources necessary to design, monitor and manage a programme:

Programme baseline data: These include mapping and age- and gender-disaggregated population size estimates, and baseline data from enrolment of people who inject drugs as they enter the programme. These data are useful to estimate the expected needle and syringe needs of people who inject drugs (as well as other commodities like condoms and lubricant) and give some gauge of risk in the population for prioritization of services.

Infrastructure and personnel: This includes the number of drop-in centres and clinics, and the number of people hired and trained, by position. These data are important to monitor service provision over the predetermined geographic area, and human resources.

Routine programme data: These include contacts between programme clients and outreach workers, outreach services and clinical services. Data should be disaggregated by gender and by

age group and can include number of new and repeat contacts, number of needles, syringes and associated injection equipment distributed, number of referrals, number enrolled in OST, number of requests for information, types of education requested, education supplied, publications produced, aggregate distribution of publications. Referral outcomes (i.e. whether an individual referred to a service attended the service, not the clinical outcome) should be assessed through an established communication channel with the referral service. Referral outcomes can be a measurement of programme effectiveness.

Box 5.5

Tracking clients across services

The mobility of some people who inject drugs makes it difficult to monitor the total number receiving services, because as they move into areas serviced by a different team or implementing organization they may be counted as a “new” to the programme. One way to address this is to ask people receiving services whether they have done so before and where; another is to provide an anonymous ID card that indicates that the individual receives services from the programme. The card should use a unique identifier code (UIC) generated by the local programme rather than the individual’s name, and it should not identify the programme by name nor identify the holder as a person who injects drugs. In some contexts it may be feasible to coordinate the UIC between service-providers within a country so that all use the same format. A local nongovernmental organization or service unit might record new contacts, new-to-area contacts and previous contacts as a way to distinguish this while capturing the degree of mobility. Whatever avenue is pursued by the programme, the tracking mechanisms need to be consistent across time to be effective.

Administrative data: Drugs and consumable supplies are managed with appropriate stock management policies and procedures. Accurate data are important to ensure consistent, uninterrupted supply of needles, syringes, condoms and lubricant and other harm-reduction commodities. The monitoring of consumption and distribution of these commodities is a marker of coverage (e.g. the number of needles and syringes distributed compared to the estimated gaps) and can corroborate clinic reporting.

Referral outcomes (i.e. whether a community member attended the service, not the clinical outcome) should be assessed through an established communication channel with the referral service.

Expenditure data: These are important to monitor the project’s financial status and ensure that payments to implementing organizations and vendors are punctual, to keep the programme running.

Surveys and qualitative assessments: These include quantitative surveys of reported condom use, needle sharing, or access to HIV and HCV services. They may be used for setting baselines or for monitoring progress. Regular qualitative assessments with programme clients can determine whether communication is being understood and whether there are unaddressed needs that could be met by the programme.

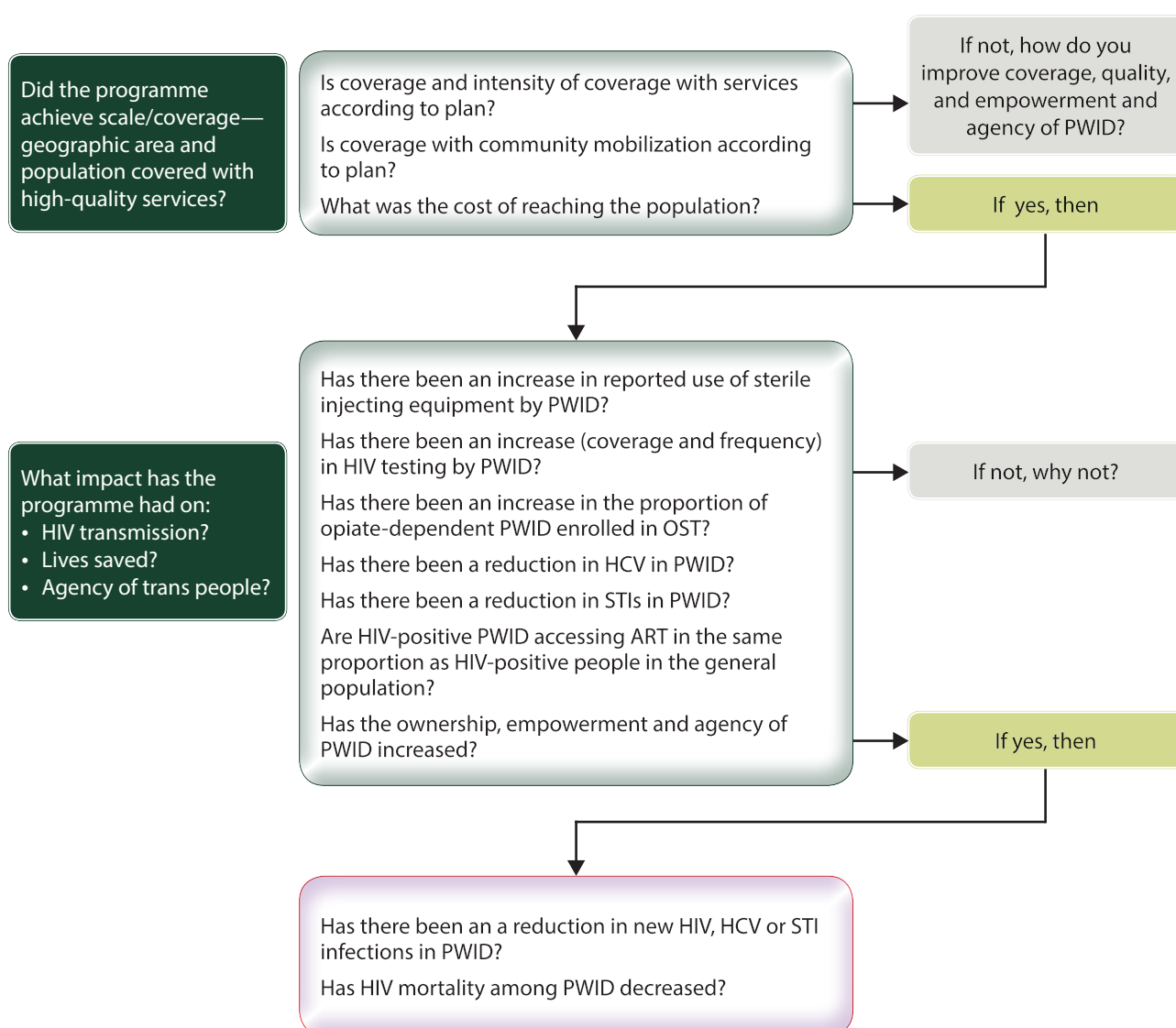
Quality monitoring: Clear standards are the foundation of quality monitoring, as services are assessed against specified standards (quality assurance). Assessments may be done externally through quality audits or using participatory approaches such as “mystery client” interviews.

Outside data: Data from sources outside the programme, such as government HIV surveillance, academic research, or surveys conducted by other institutions, may be useful to inform progress, highlight environmental issues or make necessary adjustments in the programme.

5.7.2 Evaluation

Broadly speaking, a programme evaluation assesses first how well the implementation matched the original programme design (e.g. in terms of programme content and coverage), and second the ultimate impact of the programme, i.e. its end results. Did it prevent and manage HIV and HCV within communities of people who inject drugs? Did it build capacity of the implementing organizations? An illustrative, national-programme-level evaluation framework is depicted in Figure 5.4. See Section 5.8 for guidance documents on designing evaluation programmes with people who inject drugs.

Figure 5.4 Evaluation framework for a multicomponent programme with people who inject drugs



5.7.3 Community quality assurance in monitoring and evaluation

Programmes are more effective when routine monitoring is designed with local input, and there are systems for using data at the community level. The programme at the central level should engage those managing multiple sites to determine what information is useful to them to monitor their programmes. (A simple approach is to brainstorm the aspects of the programme that they typically examine during site visits.)

Where interventions are not already community-led, community leaders should be consulted on the kinds of measures that are important to improve the quality of services and outreach. All programmes need to collect and report data to monitor progress, which can be used to hold the programme accountable to its objectives. It is important to develop a clear understanding in the community on what data will be collected, how this will happen, and how the data are to be used locally. Data should not simply be “reported up” to a higher level; an approach should be designed that also integrates monitoring for use at the local level. This is important because targets that are set at high levels are easily misinterpreted as being the primary goal of the programme, leading, for example, to focus on the number of people accessing services rather than the quality of those services or community engagement in the programme.

5.8 Further resources

1. Planning guide for the health sector response to HIV/AIDS. Geneva: World Health Organization; 2011.
http://whqlibdoc.who.int/publications/2011/9789241502535_eng.pdf
2. Planning and managing for HIV/AIDS results: a handbook. Washington (DC): Global AIDS Monitoring and Evaluation Team, World Bank Global HIV/AIDS Program; 2007.
http://siteresources.worldbank.org/INTHIVAIDS/Resources/375798-1103037153392/Results_Handbook_31Oct2007.pdf
3. Guide to the strategic planning process for a national response to HIV/AIDS. Geneva: Joint United Nations Programme on HIV/AIDS; 1998.
http://data.unaids.org/publications/IRC-pub05/jc441-stratplan-intro_en.pdf
4. Practical guidance for scaling up health service innovations. Geneva: World Health Organization and ExpandNet; 2009.
http://www.expandnet.net/PDFs/WHO_ExpandNet_Practical_Guide_published.pdf
5. Nine steps for developing a scaling-up strategy. Geneva: World Health Organization and ExpandNet; 2010.
http://whqlibdoc.who.int/publications/2010/9789241500319_eng.pdf
6. A commodity management planning guide for the scale-up of HIV counseling and testing services. Arlington (VA): Management Sciences for Health; 2008.
http://www.msh.org/sites/msh.org/files/HIV-Testing-Commodity-Guide-VCT_final.pdf
7. Management and Organizational Sustainability Tool (MOST): a guide for users and facilitators—second edition. Cambridge (MA): Management Sciences for Health; 2004.
<http://www.msh.org/resources/management-and-organizational-sustainability-tool-most>
8. Guidelines on estimating the size of populations most at risk to HIV. Geneva: World Health Organization and Joint United Nations Programme on HIV/AIDS; 2010.
http://www.who.int/hiv/pub/surveillance/estimating_populations_HIV_risk/en

9. Estimating prevalence: indirect methods for estimating the size of the drug problem. Global assessment programme on drug abuse: toolkit module 2. Vienna: United Nations Office on Drugs and Crime; 2003.
http://www.unodc.org/documents/data-and-analysis/statistics/Drugs/GAP_module_2.pdf
10. Priorities for local AIDS control efforts: a manual for implementing the PLACE method. Chapel Hill (NC): MEASURE Evaluation; 2005.
<http://www.cpc.unc.edu/measure/publications/ms-05-13>
11. Using logic models to bring together planning, evaluation, and action: logic model development guide. Battle Creek (MI): W.K. Kellogg Foundation; 2004.
<http://www.wkkf.org/knowledge-center/resources/2006/02/wk-kellogg-foundation-logic-model-development-guide.aspx>
12. Tool to set and monitor targets for HIV prevention, diagnosis, treatment and care for key populations. Geneva: World Health Organization; 2015.
<http://www.who.int/hiv/pub/toolkits/kpp-monitoring-tools/en>
13. Monitoring and evaluation systems strengthening tool. Developed by the Global Fund, PEPFAR, USAID, and others. Chapel Hill (NC): USAID Measure Evaluation Project, Carolina Population Center, University of North Carolina-Chapel Hill; 2007.
<http://www.cpc.unc.edu/measure/publications/ms-07-18>

For more information, contact:

Division for Operations

Drug Prevention and Health Branch

HIV/AIDS Section

United Nations Office on Drugs and Crime

PO Box 500

A 1400 Vienna

Austria